The FDA's Role in Regulating Access to Gender-Affirming Care Medications

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Over the last decade, many states have passed laws seeking to restrict or ban certain medications approved by the United States Food and Drug Administration (FDA). One of the most recent examples: gender-affirming care medications for transgender youth and young adults. As of January 2025, twenty-six states have passed laws banning or restricting the provision of gender-affirming care to minors. Proponents of these laws challenge the procedures and prescription drugs as "experimental," while critics of these laws characterize both as best-practice medical care. In either case, these laws demonstrate a second-guessing of the FDA's long-established authority in determining the safety of prescription drugs. Although the FDA does not regulate the practice of medicine, the effect of these healthcare regulations is to limit or prohibit access to FDA-approved medications. This inconsistency raises the question of what the FDA's role is—and should be—in protecting access to medicines.

This Article considers the FDA's role in securing access to medications, focusing on the case of gender-affirming care medications. In doing so, this Article makes three key contributions. First, this Article provides a comprehensive account of the state laws restricting access to gender-affirming care. Second, this Article analyzes how these state laws interact with federal prescription drug regulation and demonstrates the limitations of FDA authority in preempting state laws on gender-affirming care medications. Third, this Article argues that federal prescription drug regulation must be strengthened in order to protect patients' equitable access to medicines, including, but not limited to, gender-affirming care medications. Noting the historical role of the FDA in medical care and drug regulations, as well as the federalist implications of expanding this authority, this Article frames the FDA as not only a consumer protection agency, but also as an access to medicines agency. This framework will support the

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development of reforms centered at the FDA aiming to secure and expand the availability of prescription drugs for patients across the country.

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INTRODUCTION

The United States Food and Drug Administration (FDA) is tasked with evaluating new drugs and medical devices to ensure that they are safe and effective.[1] At its core, the FDA is a consumer protection and public health agency, though it also plays significant roles in incentivizing biomedical innovation, indirectly shaping medical practice, and providing access to medicines and health technologies.[2] However, the FDA is not the sole regulator in the space of medicines; states commonly set rules related to the dispensing, dosing, and utilization of medicines.[3] Often, the two parallel regulatory schemes can coexist peacefully. But, at times, conflicting state laws can undermine or frustrate the FDA's ability to fulfill its regulatory purpose in protecting public health.[4]

Over the past decades, states have passed a variety of laws setting restrictions on FDA-approved medications.[5] As part of its response to the opioid crisis, Massachusetts passed a law in 2014 banning an FDA-approved opioid, Zohydro, because it lacked abuse-deterrent properties.[6] Several states have implemented laws restricting the indications of use or amount of pills that can be prescribed at one time for other opioid products.[7] After the Supreme Court issued its opinion in *Dobbs v. Jackson Women's Health Organization* overturning the constitutional right to abortion,[8] states implemented a wide range of restrictions on medication abortions, further highlighting conflicts

1. 21 U.S.C. § 393.

2. *See generally* Rachel E. Sachs, W. Nicholson Price II & Patricia J. Zettler, *Rethinking Innovation at FDA*, 104 B.U. L. REV. 513 (2024) (arguing for the FDA's role as an innovation agency); Patricia J. Zettler, *Toward Coherent Federal Oversight of Medicine*, 52 SAN DIEGO L. REV. 427 (2015) [hereinafter Zettler, *Toward Coherent Federal Oversight*] (discussing the FDA's consumer protection and gatekeeping functions and its influence on the practice of medicine); Thomas R. Fleming, David L. Demets & Lisa M. McShane, *Discussion: The Role, Position, and Function of the FDA—The Past, Present, and Future*, 18 BIOSTATISTICS 417 (2017) (discussing the various roles of the FDA, including promoting access to medicines).

3. *See, e.g.*, Amy Lieberman & Corey Davis, *50-State Survey: Laws Limiting the Prescribing or Dispensing of Opioids*, THE NETWORK FOR PUB. HEALTH L. 1 (May 11, 2021), https://www.networkforphl.org/wp-content/uploads/2021/05/50-State-Survey-Laws-Limiting-the-Prescribing-or-Dispensing-of-Opioidspf-CSD_FINAL.pdf; Corey S. Davis & Amy Judd Lieberman, *Laws Limiting Prescribing and Dispensing of Opioids in the United States, 1989–2019*, 116 ADDICTION 1817, 1817 (2020).

4. *See What We Do*, FDA (Nov. 21, 2023) https://www.fda.gov/about-fda/what-we-do#:~:text=The%20Food%20and%20Drug%20Administration,and%20products%20that%20emit%20radiation ("The Food and Drug Administration is responsible for protecting the public health by ensuring the safety, efficacy, and security of human and veterinary drugs, biological products, and medical devices; and by ensuring the safety of our nation's food supply, cosmetics, and products that emit radiation.").

5. *See also* Patricia J. Zettler, *Pharmaceutical Federalism*, 92 IND. L.J. 845, 848 (2017) (reviewing select state regulations of prescription drugs).

6. Zogenix, Inc. v. Patrick, No. 14-11689-RWZ, slip op. at 8 (D. Mass. July 7, 2014) ("[A]ssess[ing] whether the regulations prevent[ed] the accomplishment of the FDCA's objective that safe and effective drugs be available to the public.").

7. *See* Lieberman & Davis, *supra* note 3.

8. 597 U.S. 215, 215 (2022).

between state laws on medical practice and FDA laws and regulations on prescription drugs.[9]

The complex web of conflicting state and federal drug regulations has also arisen over state laws on gender-affirming care for transgender and non-binary people, particularly youth and young adults.[10] Gender-affirming care treats gender dysphoria, or the discomfort or distress transgender or non-binary people may experience due to their bodies not matching their identified gender.[11] Gender-affirming care treatments, which can include puberty blockers, hormone therapy, and surgeries,[12] are considered best practice medical care for patients with gender dysphoria.[13] All major medical organizations, including the American Medical Association[14] and the American Academy of Pediatrics,[15] support the provision of gender-affirming care to transgender and non-binary individuals.[16]

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9. *See* David S. Cohen, Greer Donley & Rachel Rebouché, *The New Abortion Battleground*, 123 COLUM. L. REV. 1, 54–55 (2023); James M. Beck, Philip W. Danziger, Sarah B. Johansen & Andrew R. Hayes, *Federal Preemption and the Post-*Dobbs *Reproductive Freedom Frontier*, 78 FOOD & DRUG L.J. 109, 109 (2023); Patricia J. Zettler, Eli Y. Adashi & I. Glenn Cohen, Alliance for Hippocratic Medicine v. FDA—Dobbs*'s Collateral Consequences for Pharmaceutical Regulation*, 388 NEW ENG. J. MED. e29(1), e29(1) (Mar. 9, 2023) [hereinafter Zettler et al., *Collateral Consequences*]; Patricia J. Zettler, Annamarie Beckmeyer, Beatrice L. Brown & Ameet Sarpatwari, *Mifepristone, Preemption, and Public Health Federalism*, 9 J.L. & BIOSCIENCES 1, 3 (2022) [hereinafter Zettler et al., *Mifepristone*].

10. *See* Annette Choi & Will Mullery, *19 States Have Laws Restricting Gender-Affirming Care, Some with the Possibility of a Felony Charge*, CNN (June 6, 2023, 3:10 PM EDT), https://www.cnn.com/2023/06/06/politics/states-banned-medical-transitioning-for-transgender-youth-dg/index.html; Katherine L. Kraschel, Alexander Chen, Jack L. Turban & I. Glenn Cohen, *Legislation Restricting Gender-Affirming Care for Transgender Youth: Politics Eclipse Healthcare*, 3 CELL REPS. MED. 1, 1 (2022).

11. AM. PSYCHIATRIC ASS'N, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS 451 (5th ed. 2013) [hereinafter DSM-5].

12. DSM-5, *supra* note 11, at 451–59; Lindsey Dawson, Jennifer Kates & MaryBeth Musumeci, *Youth Access to Gender Affirming Care: The Federal and State Policy Landscape*, KAISER FAM. FOUND. (June 1, 2022), https://www.kff.org/other/issue-brief/youth-access-to-gender-affirming-care-the-federal-and-state-policy-landscape.

13. *See* Eli Coleman et al., *Standards of Care for the Health of Transgender and Gender Diverse People, Version 8*, 23 INT'L J. TRANSGENDER HEALTH S1, S31–S79 (2022).

14. *AMA Strengthens its Policy on Protecting Access to Gender-Affirming Care*, ENDOCRINE SOC'Y (June 12, 2023) [hereinafter *AMA Strengthens GAC Policy*], https://www.endocrine.org/news-and-advocacy/news-room/2023/ama-gender-affirming-care; *AMA to States: Stop Interfering in Health Care of Transgender Children*, AM. MED. ASS'N (Apr. 26, 2021), https://www.ama-assn.org/press-center/press-releases/ama-states-stop-interfering-health-care-transgender-children.

15. *See* Moira Szilagyi, *Why We Stand Up for Transgender Children and Teens*, AM. ACAD. PEDIATRICS (Aug. 10, 2022), https://www.aap.org/en/news-room/aap-voices/why-we-stand-up-for-transgender-children-and-teens; Jason Rafferty, *Ensuring Comprehensive Care and Support for Transgender and Gender-Diverse Children and Adolescents*, 142 PEDIATRICS 1, 4 (2018).

16. *See Medical Association Statements in Support of Health Care for Transgender People and Youth*, GLAAD (June 26, 2024), https://glaad.org/medical-association-statements-supporting-trans-youth-healthcare-and-against-discriminatory (collecting medical association statements in support of gender-affirming care);

Despite this support from the medical profession, hundreds of bills have been proposed at the state level to restrict access to gender-affirming care, with 185 bills under consideration in 2025 alone.[17] As of January 2025, twenty-six states have banned or restricted the provision of gender-affirming care to minors.[18] Some laws prohibit the provision of all gender-affirming care to minors, while others only prohibit surgeries or mandate requirements in order for the care to be permitted.[19] Penalties and remedies for violating these restrictions and prohibitions also vary.[20] Healthcare professionals may be subject to license suspension or revocation, monetary penalties, and incarceration.[21] In some states, parents could be charged with child abuse and separated from their children.[22]

These state laws are threatening the safety and access to gender-affirming care for patients across the country. Policymakers, scholars, and advocates are actively considering ways to protect access to gender-affirming care. At the federal level, the Department of Justice (DOJ) under the Biden Administration stated that gender-affirming care bans violate federal law and the U.S. Constitution.[23] At the state level, advocates and policymakers are introducing laws protecting the availability of gender-affirming care and shielding patients,

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ELANA REDFIELD, KERITH J. CONRON, WILL TENTINDO & ERICA BROWNING, UCLA SCH. OF L. WILLIAMS INST., PROHIBITING GENDER-AFFIRMING MEDICAL CARE FOR YOUTH 7 (2023) [hereinafter WILLIAMS REPORT], https://williamsinstitute.law.ucla.edu/wp-content/uploads/Trans-Youth-Health-Bans-Mar-2023.pdf; *Outlawing Trans Youth: State Legislatures and the Battle over Gender-Affirming Healthcare for Minors*, 134 HARV. L. REV. 2163, 2165 (2021) [hereinafter *Outlawing Trans Youth*].

17. *Map: Attacks on Gender Affirming Care by State*, HUMAN RTS. CAMPAIGN FOUND., https://www.hrc.org/resources/attacks-on-gender-affirming-care-by-state-map (last visited May 27, 2025); *2025 Anti-Trans Bills Tracker*, TRANS LEGIS. TRACKER, https://translegislation.com (last visited May 27, 2025). This is an increase from recent years. For example, approximately 250 bills were introduced at the state level seeking to restrict or prohibit gender-affirming care over the period 2017 to 2023. *See* Christy Mallory, Madeline G. Chin & Justine C. Lee, *Legal Penalties for Physicians Providing Gender-Affirming Care*, 329 JAMA 1821, 1821 (2023); MOVEMENT ADVANCEMENT PROJECT (MAP), LGBTQ POLICY SPOTLIGHT: BANS ON MEDICAL CARE FOR TRANSGENDER PEOPLE 7 (2023) [hereinafter MAP REPORT], https://www.mapresearch.org/file/MAP-2023-Spotlight-Medical-Bans-report.pdf.

18. For a list and summary of these laws, see Appendix, *infra*.

19. *Compare, e.g.*, S. 184, 2022 Leg., Reg. Sess. (Ala. 2022) (banning all gender-affirming care for minors in Alabama), *with* S. 1138, 55th Leg., 2d Reg. Sess. (Ariz. 2022) (banning only gender-affirming surgeries for minors in Arizona), *and* Leg. 574, 108th Leg., 1st Reg. Sess. (Neb. 2023) (banning gender-affirming surgeries and restricting other gender-affirming care with statutory requirements for access).

20. For a summary of the penalties and remedies associated with the state laws banning and restricting gender-affirming care for youth and young adults, see Appendix, *infra*.

21. MAP REPORT, *supra* note 17, at 13–14; Kraschel et al., *supra* note 10.

22. MAP REPORT, *supra* note 17, at 13–14; Kraschel et al., *supra* note 10, at 2.

23. Letter from Kristen Clarke, Assistant Attorney General Civil Rights Division, U.S. Department of Justice, to State Attorneys General (Mar. 31, 2022), https://www.justice.gov/opa/press-release/file/1489066/download.

parents, and providers from out-of-state liability.[24] Scholars are examining how these laws fit into or challenge current paradigms, including constitutional law,[25] criminal law,[26] discrimination law,[27] family law,[28] insurance law,[29] and reproductive rights law.[30] Many scholars have emphasized how these state laws are inconsistent with both standard medical practice and bioethical principles.[31]

This Article adds to these ongoing discussions by examining the challenges posed by state laws restricting gender-affirming care through the lenses of FDA law and preemption law, focusing broadly on the role and authority of the FDA in approving and ensuring equal access to prescription drugs. FDA regulations

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24. *Transgender Healthcare "Shield" Laws*, MOVEMENT ADVANCEMENT PROJECT (Mar. 11, 2025), https://www.lgbtmap.org/equality-maps/healthcare/trans_shield_laws ("For example, if a person travels from a state where healthcare is banned and receives that care in another state, a 'shield' law can protect the recipient and/or provider of that healthcare against civil or criminal charges from the state where healthcare is banned."); WILLIAMS REPORT, *supra* note 16, at 8–9; Dawson et al., *supra* note 12.

25. *See generally* Lewis A. Grossman, *Criminalizing Transgender Care*, 110 IOWA L. REV. 281 (2024) (arguing that laws interfering with standard of care treatment violate a fundamental right under the Due Process clause of the Fourteenth Amendment).

26. *See generally* Teneille R. Brown, *When Doctors Become Cops*, 97 S. CAL. L. REV. 675 (2024) (discussing various legal tests for sex discrimination).

27. *See generally* Jessica A. Clarke, *Sex Discrimination Formalism*, 109 VA. L. REV. 1699 (2023) [hereinafter Clarke, *Sex Discrimination Formalism*] (discussing various legal tests for sex discrimination). Jessica A. Clarke, *Sex Assigned At Birth*, 122 COLUM. L. REV. 1821 (2022) [hereinafter Clarke, *Sex Assigned At Birth*] (cautioning that while "sex assigned at birth" is an important concept, it is not sufficient to secure victories in transgender rights litigation).

28. *See generally* Clare Huntington, *Pragmatic Family Law*, 136 HARV. L. REV. 1501 (2023); Courtney G. Joslin & Catherine Sakimura, *Fractured Families: LGBTQ People and the Family Regulation System*, 13 CALIF. L. REV. 78 (2022); Naomi Cahn, *The Political Language of Parental Rights: Abortion, Gender-Affirming Care, and Critical Race Theory*, 53 SETON HALL L. REV. 1443 (2023) (discussing legal research on issues regarding gender affirming care in family law).

29. *See generally* Diane Kemker, *When Gender-Affirming Healthcare Becomes Illegal, Will It (Still) Be Tax-Deductible?*, 25 GEO. J. GENDER & L. 83 (2023); Richard Luedeman, *Health Plan Coverage for Gender-Affirming Care: Continued Shortcomings at the Federal Level and a Role for Progressive States*, 22 NEV. L.J. 1071 (2022) (discussing insurance coverage and tax implications of gender affirming care).

30. *See generally* Robin Maril, *From Liberation To (Re)Criminalization:* Dobbs v. Jackson Women's Health Organization*, Bodily Autonomy, and the Expansion of State Rights*, 76 SMU L. REV. 551 (2023); Elizabeth Kukura, *Reconceiving Reproductive Health Systems: Caring for Trans, Nonbinary, and Gender-Expansive People During Pregnancy and Childbirth*, 50 J.L., MED. & ETHICS 471 (2022) (explaining barriers to health care and reproductive rights for transgender individuals).

31. *See, e.g.*, Scott J. Schweikart, *What's Wrong With Criminalizing Gender-Affirming Care of Transgender Adolescents?*, 25 AMA J. ETHICS 414, 415 (2023) (describing various state statutes criminalizing gender-affirming care for adolescent patients); Landon D. Hughes, Kacie M. Kidd, Kristi E. Gamarel, Don Operario & Nadia Dowshen, *"These Laws Will Be Devastating": Provider Perspectives on Legislation Banning Gender-Affirming Care for Transgender Adolescents*, 69 J. ADOLESCENT HEALTH 976, 976–82 (2021) (surveying providers who deliver gender affirming care); Kraschel et al., *supra* note 10 (arguing that bills restricting access to gender affirming care are an assault on individuals and physicians, and that such laws restrict the ability to make health care choices); *see also* Laura L. Kimberly et al., *Ethical Issues in Gender-Affirming Care for Youth*, 142 PEDIATRICS 1, 3 (2018) (discussing the ethics of gender-affirming care for minors independent of the state bans and restrictions).

are increasingly blurring with state regulations of medical practice,[32] and unique aspects of the approval and use of gender-affirming care medications distinguish them from other cases at the intersection of FDA law and state medical practice law, including in the context of abortion and opioids.[33] Each of these challenges raises different questions regarding the scope of FDA preemption, the implications of healthcare federalism, and the role of the FDA as a federal regulator and gatekeeper to the pharmaceutical market.

This Article makes three key contributions. First, this Article provides a comprehensive account of the current state laws restricting access to gender-affirming care. In doing so, it highlights the scope of the laws, the extent of their bans and restrictions, and their interaction with the FDA's regulatory authority. Second, this Article analyzes how these state laws interact with federal prescription drug regulation and demonstrates the limitations of FDA authority in preempting state laws on gender-affirming care medications and protecting patients' rights. In determining that the FDA's preemptive authority does not go far enough to supersede the state bans and restrictions on gender-affirming care medications, this Article argues that federal prescription drug regulation must be strengthened in order to protect patients' access to medicines, including, but not limited to, gender-affirming care medications. Considering the historical and current scope and mission of the FDA and impact on rebalancing the current system of healthcare federalism, this Article concludes with potential solutions, including greater preemptive authority and a new abbreviated regulatory pathway. In doing so, this Article reframes the role of the FDA as not only one of consumer protection, but also as one with a mission and duty to promote and protect access to medicines.

This Article proceeds in three parts. Part I provides a brief background on gender-affirming care to contextualize the state laws within medical practice. It then reviews the provisions of the various states' laws restricting access to gender-affirming care. Noting the existing cases and investigations challenging these laws and the nature of their arguments, Part II considers how these laws interact with FDA regulations. After describing the preemption doctrine as it applies to the Federal Food, Drug, and Cosmetics Act ("FDCA"), this Part assesses the impact of these state laws on prescription drug regulation, describing how the FDA's role in regulating the safety and effectiveness of medications and its lack of regulation of the practice of medicine pose challenges

32. *See, e.g.*, Myrisha S. Lewis, *Halted Innovation: The Expansion of Federal Jurisdiction Over Medicine and the Human Body*, 2018 UTAH L. REV. 1073 [hereinafter Lewis, *Halted Innovation*] (arguing that innovations in the life sciences fall outside the jurisdiction of the FDA); Myrisha S. Lewis, *Innovating Federalism in the Life Sciences*, 92 TEMPLE L. REV. 383 (2020) [hereinafter Lewis, *Innovating Federalism*] (challenging the notion that the FDA has exclusive jurisdiction over innovations in life sciences).

33. *See* Zettler, *supra* note 5, at 872–75; Cohen et al., *supra* note 9, at 52–99.

in protecting access to gender-affirming care. Part II concludes that current doctrine is largely unable to protect access to gender-affirming care medications, necessitating reforms to the current system.

With the goal of promoting access to medicines, both in the context of gender-affirming care and in other future contexts, Part III discusses the value of centering solutions to access to medicines at the FDA. It first evaluates the key considerations in expanding the FDA's authority over state prescription drug regulations under key principles of bioethics and healthcare federalism. Then, focusing on the historical and developing conceptions of the role of the FDA, Part III proceeds by proposing two solutions to protecting access to gender-affirming care medications and evaluates their strengths and weaknesses. The first solution suggests expanding the FDA's preemptive authority broadly over all prescription drugs. The second solution suggests creating a new pathway for the FDA to review and perhaps seeking and promoting approval of known, unapproved indications, or uses, of medications. In any case, these solutions would increase the reach of the FDA into the states to protect and expand patients' access to medicines and strengthen its role in consumer protection and consumer access. Such a role would allow the FDA to more directly pursue health equity, including for transgender and non-binary people.

I. GENDER-AFFIRMING CARE: THE LAW AND THE MEDICINE

The surge in laws restricting gender-affirming care has accompanied a swath of laws targeting the LGBTQ+ community.[34] The American Civil Liberties Union ("ACLU") identified 510 anti-LGBTQ bills in state legislatures in 2023 and 574 in 2024.[35] These include bills regulating bathroom use, pronoun use in public schools, and identity-changing documents.[36] Due to the rise in anti-LGBTQ+ laws, the Human Rights Campaign declared the first-ever national state of emergency for the LGBTQ+ community on June 6, 2023.[37]

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34. MAP REPORT, *supra* note 17, at 1; *see* Clarke, *Sex Assigned at Birth*, *supra* note 27, at 1825–27 (describing how laws targeting the trans community in particular increased after the Supreme Court's opinion in *Bostock v. Clayton County*, 590 U.S. 644 (2020)).

35. *Mapping Attacks on LGBTQ Rights in U.S. State Legislatures in 2023*, ACLU, https://www.aclu.org/legislative-attacks-on-lgbtq-rights-2023 (last visited Dec. 15, 2024); *Mapping Attacks on LGBTQ Rights in U.S. State Legislatures in 2024*, ACLU, https://www.aclu.org/legislative-attacks-on-lgbtq-rights-2024 (last visited Dec. 15, 2024).

36. MAP REPORT, *supra* note 17, at 18.

37. Holly Yan, *Human Rights Campaign Declares a National State of Emergency for LGBTQ+ People*, CNN (June 6, 2023), https://www.cnn.com/2023/06/06/us/hrc-lgbtq-emergency-declared/index.html (citing *National State of Emergency for LGBTQ+ Americans*, HUM. RTS. CAMPAIGN, https://www.hrc.org/campaigns/national-state-of-emergency-for-lgbtq-americans (last visited Aug. 1, 2023)). The collective actions of states have raised concerns internationally, with Canada even issuing a travel advisory due to state laws targeting the LGBTQ+ community. *See* Associated Press, *Canada Issues Travel Advisory*

Included in these state actions were those restricting access to gender-affirming care in states across the country.[38] This Part details the twenty-six gender affirming care laws and their impact on patients. Subpart A defines gender dysphoria and gender-affirming care, including the various drugs and treatments involved. Subpart A also reviews the medical literature supporting its use, including for minors. Subpart B describes the state laws passed and state bills proposed to prohibit or restrict gender-affirming care, identifying what state laws are restricting, the associated penalties, and the potential reach of these laws. Subpart C discusses the litigation brought challenging these laws. With this context, this Part frames the ongoing problem within both the current legal sphere and the healthcare system.

A. GENDER DYSPHORIA AND GENDER-AFFIRMING CARE

Approximately 0.5 percent of adults and 1.4 percent of adolescents ages thirteen to seventeen identify as transgender.[39] Some transgender and non-binary people may, at some point, experience gender dysphoria, which is the discomfort or distress that some transgender and non-binary people may or may not experience due to their bodies not matching their identified gender.[40] To be diagnosed with gender dysphoria, an individual's distress must impair their social, school, occupational, or other areas of functioning.[41]

Gender-affirming care in this context refers to medical care for people with gender dysphoria, which encompasses a broad range of medical services (including mental health, primary care, endocrinology, and surgical services)[42]

Warning Over U.S. States' LGBTQ+ Laws, NPR (Sept. 1, 2023, 4:57 AM ET), https://www.npr.org/2023/09/01/1197169683/canada-issues-travel-advisory-warning-over-u-s-states-lgbtq-laws#:~:text=David%20Mulroney%2C%20Canada%27s%20former%20ambassador,and%20its%20supporters%20disagree%20with.

38. *See infra* Appendix.

39. JODY L. HERMAN, ANDREW R. FLORES & KATHRYN K. O'NEILL, HOW MANY ADULTS AND YOUTH IDENTIFY AS TRANSGENDER IN THE UNITED STATES? 9 (2022), https://williamsinstitute.law.ucla.edu/wp-content/uploads/Trans-Pop-Update-Jun-2022.pdf.

40. *See* DSM-5, *supra* note 11, at 453 (describing gender dysphoria as the "marked incongruence between the gender [an individual has] been assigned . . . and their experienced/expressed gender"). Individuals with gender dysphoria may or may not present with distress related to their existing (in adults) or anticipated (in adolescents) primary and secondary sex characteristics and an asserted desire to be the other gender and to be treated as the other gender. *See id.* at 451–52. It may present differently in children. For example, children with gender dysphoria may express a desire to dress in clothing associated with the other gender, to play with toys associated with the other gender, to prefer playmates of the other gender. *Id.* They may also express a rejection of toys associated with their assigned gender. *Id.*

41. *See id.* at 452–53. Notably, the experienced distress is related to transgender individuals' experiences in their bodies, not due to the stigma associated with being transgender. *See id.*

42. *Id.* at 458; Ha Le, *Further Defining Gender-Affirming Care*, AM. ACADEMY OF PEDIATRICS J. BLOG (Dec. 22, 2023), https://publications.aap.org/journal-blogs/blog/27752/Further-Defining-Gender-Affirming-Care?autologincheck=redirected. While some sources include all "social, psychological, behavioral, [and]

and non-medical services (including legal name changes and changes in social presentation and appearance, such as hairstyle and clothing).[43] Depending on an individual's dysphoria symptoms, health, and desires, they may choose to seek all, some, or none of the available treatments.[44] Generally speaking, however, gender-affirming care can be structured into lines or categories of treatment. Each line or category builds upon the previous one but is not necessarily turned to because a previous stage was ineffective.

1. Categories of Gender-Affirming Care

The first line or category of gender-affirming care, especially for children and adolescents, is often psychotherapy.[45] Individuals who receive a diagnosis of gender dysphoria work with a therapist on issues related to their stresses and

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medical" interventions in the definition of "gender-affirming care," see, for example, Dawson et al., *supra* note 12, this Article will use "gender-affirming care" only to refer to the medical interventions. This is because state laws generally exclude these from the statutory definitions of "gender-affirming care." *See infra* Part.II.B. and Appendix.

43. *See Study Finds That Early Social Transition for Transgender Youth Results in Good Mental Health Outcomes, but Unaccepting School Environments May Lead To Greater Risk of Suicidality*, FENWAY HEALTH (July 27, 2021) (citing Jack L. Turban, Dana King, Jason J. Li & Alex S. Keuroghlian, *Timing of Social Transition for Transgender and Gender Diverse Youth, K-12 Harassment, and Adult Mental Health Outcomes*, 69 J. ADOLESCENT HEALTH 991, 993 (2021)), https://fenwayhealth.org/study-finds-that-early-social-transition-for-transgender-youth-results-in-good-mental-health-outcomes-but-unaccepting-school-environments-may-lead-to-greater-risk-of-suicidality; Renuka Rayasam, *The Transgender Care That States Are Banning, Explained*, POLITICO (Mar. 25, 2022, 7:00 PM EDT), https://www.politico.com/newsletters/politico-nightly/2022/03/25/the-transgender-care-that-states-are-banning-explained-00020580; *see also Outlawing Trans Youth*, *supra* note 16, at 2169 (discussing the benefits of social transition for transgender youth).

44. *See* DSM-5, *supra* note 11, at 451 ("Although not all individuals will experience distress from incongruence, many are distressed if the desired physical interventions using hormones and/or surgery are not available."); Dawson et al., *supra* note 12.

45. *Cf.* DSM-5, *supra* note 11, at 451; *AMA Strengthens GAC policy*, *supra* note 14; Rayasam, *supra* note 43. Medical professionals disagree, however, as to whether psychotherapy should be required before other gender-affirming treatments. Dr. Laura Edwards-Leeper, a child clinical psychologist and one of the authors of the adolescent chapter of the World Professional Association for Transgender Health, supports requiring therapy as part of gender-affirming care, especially for children. Azeen Ghorayshi, *Doctors Debate Whether Trans Teens Need Therapy Before Hormones*, N.Y. TIMES (Jan. 13, 2022), https://www.nytimes.com/2022/01/13/health/transgender-teens-hormones.html. She has argued that trans youth "absolutely have to be treated differently" than adults and points to adolescents increasingly seeking treatment related to questioning gender, but not distress signifying gender dysphoria. *Id.* In contrast, Dr. Alex Keuroghlian, a clinical psychiatrist at Fenway Health in Boston and the director of the Massachusetts General Hospital Psychiatry Gender Identity Program, does not support requiring therapy as part of gender-affirming care as "[b]eing trans isn't a mental health problem." *Id.* Still, many transgender people experience mental health conditions, including anxiety, depression, and suicidal ideation, related to gender dysphoria that may be treated by other gender-affirming care. *See* DSM-5, *supra* note 11, at 458–59; *Outlawing Trans Youth*, *supra* note 16, at 2168 (citing Johanna Olson, Sheree M. Schrager, Marvin Belzer, Lisa K. Simons & Leslie F. Clark, *Baseline Physiologic and Psychosocial Characteristics of Transgender Youth Seeking Care for Gender Dysphoria*, 57 J. ADOLESCENT HEALTH 374, 379 (2015)).

other concerns that may come up related to this disorder.[46] Before puberty, transgender youth typically do not receive gender-affirming care beyond therapy and support for social transitioning.[47]

The second category of gender-affirming care is non-surgical medical treatments. Non-surgical gender-affirming care includes puberty blockers and hormone therapy (referred to collectively throughout this Article as "gender-affirming care medications").[48] As puberty happens at different times for every child depending on a variety of factors,[49] the exact ages when an individual may require gender-affirming care similarly varies. Standards of care do not set minimum age requirements for the use of these medications, but puberty blockers are generally used for children about to start puberty (at least eight or nine)[50] and hormone therapies are generally prescribed to adolescents and young adults (at least sixteen) or adults (over eighteen).[51] Some organizations, including the World Professional Association for Transgender Health, have issued standard of care guidance consistent with these age ranges.[52] It is important to note while these drugs are considered the standard of care for treating gender dysphoria, and have been used for decades, they are not FDA-approved for the treatment of gender dysphoria.[53]

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46. *Outlawing Trans Youth*, *supra* note 16, at 2166 (citing WORLD PRO. ASS'N FOR TRANSGENDER HEALTH, STANDARDS OF CARE FOR THE HEALTH OF TRANSSEXUAL, TRANSGENDER, AND GENDER-NONCONFORMING PEOPLE 14, 18–19 (7th ed. 2012)); Johanna Olson, Catherine Forbes & Marvin Belzer, *Management of the Transgender Adolescent*, 165 ARCHIVES PEDIATRIC & ADOLESCENT MED. 171, 173–174 (2011); Leigh A. Spivey & Laura Edwards-Leeper, *Future Directions in Affirmative Psychological Interventions with Transgender Children and Adolescents*, 48 J. CLINICAL CHILD & ADOLESCENT PSYCH. 343, 347–48 (2019).

47. Dov Fox, *Medical Disobedience*, 136 HARV. L. REV. 1030, 1056 (2023) (citing Ilana Sherer & Madeleine Hanks, *Affirming Pediatric Care for Transgender and Gender Expansive Youth*, 50 PEDIATRIC ANNALS e65, e68 (2021); Wylie C. Hembree, Peggy T. Cohen-Kettenis, Louis Gooren, Sabine E. Hannema, Walter J. Meyer, M. Hassan Murad, Stephen M. Rosenthal, Joshua D. Safer, Vin Tangpricha & Guy G. T'Sjoen, *Endocrine Treatment of Gender-Dysphoric/Gender-Incongruent Persons: An Endocrine Society Clinical Practice Guideline*, 102 J. CLINICAL ENDOCRINOLOGY & METABOLISM 3869, 3894 (2017); Caroline Salas-Humara, Gina M. Sequeira, Wilma Rossi & Cherie Priya Dhar, *Gender Affirming Medical Care of Transgender Youth*, CURRENT PROBS. PEDIATRIC & ADOLESCENT HEALTH CARE, Sept. 2019, at 1, 2).

48. Dawson et al., *supra* note 12.

49. *See, e.g.*, *Puberty and Precocious Puberty*, NAT'L INST. OF CHILD HEALTH & HUM. DEV., https://www.nichd.nih.gov/health/topics/factsheets/puberty#:~:text=The%20onset%20of%20puberty%2C%20the,puberty%20that%20begins%20abnormally%20late (last visited Dec. 15, 2024).

50. *See* Rayasam, *supra* note 43 ("Clinicians who treat transgender children wait until the start of puberty, which can begin as early as 8 or 9, before considering puberty blockers.").

51. *See, e.g.*, Ghorayshi, *supra* note 45 ("The guidelines suggest minimum ages, lower than those in the previous version, for each treatment: 14 for starting hormone therapy, 15 for chest masculinization and at least 17 for more invasive genital operations.")

52. *See Outlawing Trans Youth*, *supra* note 16, at 2166; *see also* Coleman et al., *supra* note 13, at S43 (updating guidance from WPATH).

53. *See* Sophia Geffen, Tim Horn, Kimberleigh Joy Smith & Sean Cahil, *Advocacy for Gender Affirming Care: Learning from the Injectable Estrogen Shortage*, 3 TRANSGENDER HEALTH 42, 43 (2018).

Puberty blockers are medications that affect the sex hormones (estrogen and testosterone) to delay certain aspects of puberty related to gender expression, including breast growth, menstruation, and facial hair growth.[54] Children may take puberty blockers to have "more time to process their identity and decide whether to pursue further steps in transition and to prevent irreversible physical changes that conflict with their desired gender presentation and increase dysphoria."[55] These drugs, most commonly gonadotropin-releasing hormone ("GnRH") analogs, are FDA-approved for the treatment of early-onset puberty in children[56] but have been used off-label for transgender youth for decades.[57] The use of puberty blockers has no confirmed irreversible effects, instead simply acting as a pause button on the progression of puberty.[58] However, some studies have suggested that the use of puberty blockers can result in decreased bone density and fertility issues.[59]

Hormone therapies are provided to individuals who wish to make their secondary sexual characteristics more consistent with their gender identity.[60] These include testosterone hormone therapy for transgender men and estrogen and anti-androgen hormone therapy for transgender women.[61] These can be administered starting around age sixteen and cause the development of secondary sex characteristics consistent with the individual's identified gender.[62] Depending on the stage of administration, hormone therapy may be

54. *See About Puberty Blockers*, DOERNBECHER'S CHILD.'S HOSP., https://www.stlouischildrens.org/conditions-treatments/transgender-center/puberty-blockers (last visited Aug. 2, 2023); *Puberty Blockers for Transgender and Gender-Diverse Youth*, MAYO CLINIC (June 14, 2023), https://www.mayoclinic.org/diseases-conditions/gender-dysphoria/in-depth/pubertal-blockers/art-20459075; Fox, *supra* note 47.

55. *Outlawing Trans Youth*, *supra* note 16, at 2166 (citing Simone Mahfouda, Julia K. Moore, Aris Siafarikas, Florian D. Zepf & Ashleigh Lin, Review, *Puberty Suppression in Transgender Children and Adolescents*, 5 LANCET DIABETES & ENDOCRINOLOGY 816, 816–18 (2017)); WORLD PRO. ASS'N FOR TRANSGENDER HEALTH, STANDARDS OF CARE FOR THE HEALTH OF TRANSSEXUAL, TRANSGENDER, AND GENDER-NONCONFORMING PEOPLE 19 (7th ed. 2012) [hereinafter WPATH SOC].

56. *See, e.g.*, *Fensolvi (Leuprolide Acetate)*, FDA 1 (Apr. 2022), https://www.accessdata.fda.gov/drugsatfda_docs/label/2022/213150s002lbl.pdf (approved for precocious puberty). Puberty blockers have some side effects, including loss of fertility and bone density, but these effects may be reversed. Rayasam, *supra* note 43; Ghorayshi, *supra* note 45.

57. *See, e.g.*, Simona Giordano & Søren Holm, *Is Puberty Delaying Treatment 'Experimental Treatment'?*, 21 INT'L J. TRANSGENDER HEALTH 113, 118 (2020) (citing studies and guidances on the use of puberty blockers for gender dysphoria in transgender adolescents since the late 1990s and in transgender children since the early 2000s).

58. *See* Coleman et al., *supra* note 13, at S112.

59. *See id.* at 153.

60. Patti Zielinski, *Laws and Conversion Therapy Threaten Trans Youth*, FUTURITY (June 8, 2023), https://www.futurity.org/gender-affirming-care-conversion-therapy-2930382-2.

61. *Transgender Hormone Therapy*, PLANNED PARENTHOOD, https://www.plannedparenthood.org/get-care/our-services/transgender-hormone-therapy (last visited Mar. 12, 2025).

62. *Outlawing Trans Youth*, *supra* note 16, at 2166–67.

partially reversible or nonreversible.[63] Similar to puberty blockers, they are not FDA-approved for the treatment of gender dysphoria: testosterone is approved for "use in men who lack or have low testosterone levels in conjunction with an associated medical condition"[64] and estrogen is approved for restoring hormone levels in cisgender women, typically related to menopause.[65] They, too, however, have been used off-label for decades to treat transgender patients.[66]

The third and final line of gender-affirming care is surgical medical treatments (sometimes called "gender-affirming surgeries").[67] These voluntary surgical procedures are intended to change an individual's primary or secondary sex characteristics.[68] These include surgeries to make facial features more masculine or feminine, breast augmentation or mastectomy, and surgeries on reproductive organs.[69] Surgeries are rarely performed upon individuals under the age of eighteen[70] and many are not reversible.[71]

2. Risks and Benefits of Gender-Affirming Care

Without treatment, gender dysphoria is associated with depression, social anxiety, suicidal ideation, suicidal behavior, and other mental health conditions[72] at rates higher than the general population.[73] These conditions are particularly prevalent in transgender youth, who experience suicidal thoughts and attempts at a rate three times higher than the general population.[74] One study

63. Rayasam, *supra* note 43.

64. *Testosterone Information*, FDA (Mar. 3, 2015), https://www.fda.gov/drugs/postmarket-drug-safety-information-patients-and-providers/testosterone-information.

65. *See* Geffen et al., *supra* note 53; FDA, MENOPAUSE & HORMONES: COMMON QUESTIONS 1 (Dec. 5, 2019), https://www.fda.gov/media/130242/download.

66. *See generally* Coleman et al., *supra* note 13 (explaining that gender-affirming treatments are based on decades of clinical research and are both safe and effective in terms of reducing gender dysphoria).

67. Although gender-affirming care surgeries will be discussed throughout this Article in relation to the state laws restricting them, the focus on this Article will be the FDA's authority related to gender-affirming care medications.

68. *Outlawing Trans Youth*, *supra* note 16, at 2167.

69. *See* Coleman et al., *supra* note 13, at S18.

70. *Outlawing Trans Youth*, *supra* note 16, at 2165–67; *AMA Strengthens GAC Policy*, *supra* note 14; Rayasam, *supra* note 43.

71. Rayasam, *supra* note 43; Coleman et al., *supra* note 13, at S41.

72. *Outlawing Trans Youth*, *supra* note 16, at 2168 (citing TREVOR PROJECT, NATIONAL SURVEY ON LGBTQ YOUTH MENTAL HEALTH 2020, at 3 (2020), https://www.thetrevorproject.org/wp-content/uploads/2020/07/The-Trevor-Project-National-Survey-Results-2020.pdf); Johanna Olson, Sheree M. Schrager, Marvin Belzer, Lisa K. Simons & Leslie F. Clark, *Baseline Physiologic and Psychosocial Characteristics of Transgender Youth Seeking Care for Gender Dysphoria*, 57 J. ADOLESCENT HEALTH 374, 378 (2015).

73. *What Is Gender Dysphoria?*, AM. PSYCHIATRIC ASS'N (Aug. 2022), https://www.psychiatry.org/patients-families/gender-dysphoria/what-is-gender-dysphoria.

74. *Outlawing Trans Youth*, *supra* note 16, at 2168 (citing Olson et al., *supra* note 72, at 379).

reported that more than one-third of transgender high school students attempt suicide each year.[75]

Gender-affirming care is effective in treating gender dysphoria and the mental health conditions related to it.[76] Studies have shown that gender-affirming care, including hormone therapies and surgeries, is associated with improving depression, anxiety, suicidal ideation, and suicidal behavior in transgender adults.[77] These benefits are also seen for transgender children and youth.[78] Puberty blockers are associated with a decrease in suicidal ideation,[79] and children who begin gender-affirming care in youth have lower rates of depression, anxiety, and suicidal ideation than those who do not receive such care.[80] One study found that hormone therapy reduces the risk of suicide for transgender minors by 14 percent.[81] Further, as low as 2 percent of individuals studied later discontinue gender-affirming care or detransition.[82] Rates of patients experiencing any kind of regret related to gender-affirming care are similarly low, with high estimates around 1.5 percent.[83] This is significantly

75. *Id.* at 2163.

76. Jack L. Turban, Dana King, Julia Kobe, Sari L. Reisner & Alex S. Keuroghlian, *Access to Gender-Affirming Hormones During Adolescence and Mental Health Outcomes Among Transgender Adults*, PLOS ONE, Jan. 16, 2022, at 1, 2.

77. DSM-5, *supra* note 11.

78. *Outlawing Trans Youth*, *supra* note 16, at 2168 (citing Annelou L.C. de Vries, Jenifer K. McGuire, Thomas D. Steensma, Eva C. F. Wagenaar, Theo A.H. Doreleijers & Peggy T. Cohen-Kettenis, *Young Adult Psychological Outcome After Puberty Suppression and Gender Reassignment*, PEDIATRICS, Oct. 2014, at 1, 6–7); Fox, *supra* note 47, at 1057 (citing Kristina R. Olson, Lily Durwood, Rachel Horton, Natalie M. Gallagher & Aaron Devor, *Gender Identity 5 Years After Social Transition*, PEDIATRICS, Aug. 2022, at 1, 1–2; Jack L. Turban, Dana King, Jeremi M .Carswell & Alex S. Keuroghlian, *Pubertal Suppression for Transgender Youth and Risk of Suicidal Ideation*, PEDIATRICS, Feb. 2020, at 1, 5); Turban et al., *supra* note 76, at 9–10.

79. Daylina Miller, *These Trans Advocates Say the New Informed Consent Forms for Patients Are Transphobic and Inaccurate*, WUSF NPR (July 24, 2023, 5:00 AM EST), https://wusfnews.wusf.usf.edu/health-news-florida/2023-07-24/trans-advocates-new-informed-consent-forms-transphobic-inaccurate.

80. Fox, *supra* note 47, at 1057 (citing Kristina R. Olson, Lily Durwood, Rachel Horton, Natalie M. Gallagher & Aaron Devor, *Gender Identity 5 Years After Social Transition*, PEDIATRICS, Aug. 2022, at 1, 1–2; Jack L. Turban, Dana King, Jeremi M .Carswell & Alex S. Keuroghlian, *Pubertal Suppression for Transgender Youth and Risk of Suicidal Ideation*, PEDIATRICS, Feb. 2020, at 1, 5).

81. Zielinski, *supra* note 60. (citing Travis Campbell, Samuel Mann, Duc Hien Nguyen & Yana van der Meulen Rogers, *Hormone Therapy, Suicidal Risk, and Transgender Youth in the United States*, 113 AM. ECON. ASS'N PAPERS AND PROC. 551, 551 (2023)).

82. Maria Anna Theodora Catharina van der Loos, Sabine Elisabeth Hannema, Daniel Tatting Klink, Martin den Heijer & Chantal Maria Wiepjes, *Continuation of Gender-Affirming Hormones in Transgender People Starting Puberty Suppression in Adolescence: A Cohort Study in the Netherlands*, 6 LANCET CHILD & ADOLESCENT HEALTH 869, 869 (2022) ("704 (98%) people who had started gender-affirming medical treatment in adolescence continued to use gender-affirming hormones at follow-up.").

83. Robin Respaut, Chad Terhune & Michelle Conlin, *Why Detransitioners Are Crucial to the Science of Gender Care*, REUTERS (Dec. 22, 2022, 12:00 GMT), https://www.reuters.com/investigates/special-report/usa-transyouth-outcomes.

lower than regret for other procedures, including breast augmentation (5.1-9.1 percent) and bariatric surgery (19.5 percent).[84]

Maintaining access to gender-affirming care is both essential and lifesaving. In one survey, 39 percent of respondents reported that losing access to gender-affirming care would harm their mental health.[85] One individual stated, "If I didn't have it, I quite literally would be dead right now. I attempted suicide many[,] many times before I got care. Not once since."[86] Another respondent reported, "I would kill myself without gender[-]affirming care, it's the only thing worth living for: the potential that someday I might be able to be myself."[87] With these notable risks and strong benefits, it is unsurprising that all major medical organizations, including the American Medical Association and the American Academy of Pediatrics, support the provision of gender-affirming care to transgender and non-binary individuals, including minors.[88]

B. STATE LAWS ON GENDER-AFFIRMING CARE

Despite the medical community's support, politicians continue to oppose gender-affirming care. States are increasingly proposing bills to ban gender-affirming care, from four bills in 2018 to 118 bills by April 2023.[89] Almost all of these bills restrict only gender-affirming care for minors (under age eighteen, under age nineteen in Alabama and Nebraska),[90] though some bills are also banning gender-affirming care for young adults.[91] One draft bill in Oklahoma, for example, would have banned gender-affirming surgeries for individuals up to age twenty-six.[92] Others state bills and laws are restricting access by prohibiting Medicaid coverage of gender-affirming care, with ten states

84. Sarah M. Thornton, Armin Edalatpour, & Katherine M. Gast, *A Systematic Review of Patient Regret After Surgery—A Common Phenomenon in Many Specialties but Rare Within Gender-Affirmation Surgery*, 234 AM. J. SURGERY 68, 70 (2024).

85. Lindsay Y. Dhanani & Rebecca R. Totton, *Have You Heard the News? The Effects of Exposure to News About Recent Transgender Legislation on Transgender Youth and Young Adults*, 20 SEXUALITY RSCH. & SOC. POL'Y 1345, 1354 (2023).

86. *Id.*

87. *Id.*

88. *See supra* notes 14–16 and accompanying text.

89. Mallory et al., *supra* note 17.

90. MAP REPORT, *supra* note 17, at 12; *see also* ALA. CODE § 26-1-1(a) (2025) (Alabama age of majority); NEB. REV. STAT. ANN. § 43-2101(1) (West 2025) (Nebraska age of majority); S. 184, 2022 Leg., Reg. Sess. (Ala. 2022) (Alabama gender-affirming care law); Leg. 574, 108th Leg., Reg. Sess. (Neb. 2023) (Nebraska gender-affirming care law).

91. Although the majority of the laws target gender-affirming care for minors specifically, this Article's arguments apply to gender-affirming care for minors and adults. In the context of minors, these arguments will have greater impacts on third parties, such as parents and guardians. This Article, however, focuses on the laws' implications on access to care for the individual patient, and therefore considers both minor and adult patients.

92. S. 129, 59th Leg., Reg. Sess. (Okla. 2023) (as introduced Jan. 4, 2023).

explicitly excluding gender-affirming care from Medicaid coverage for all age groups.[93]

As of January 2025, twenty-six states have passed laws banning or restricting gender-affirming care.[94] Bills have been introduced in at least another nine states.[95] These laws have different provisions related to gender-affirming medications and surgeries. Laws in both Arizona and New Hampshire only ban gender-affirming surgeries and do not have a provision on gender-affirming medications (puberty blockers and hormone therapies).[96] Twenty-five states (including Arizona) ban all gender-affirming surgeries for minors,[97] while twenty states ban all or some gender-affirming medications.[98] Three states—Nebraska, Utah, and West Virginia—ban all gender-affirming surgeries but only restrict access to one or both categories of gender-affirming medications.[99] Restrictions may include psychotherapy, medical evaluations, additional documentation in medical records, and additional informed consent procedures.[100]

Arkansas, unlike all other states restricting access to gender-affirming care,[101] does not ban gender-affirming surgeries or gender-affirming medications but sets a very high bar for access.[102] An individual must have (1) consistently experienced gender dysphoria for two years, as diagnosed by a healthcare professional, (2) obtain in writing from at least two healthcare professionals, including one mental health professional, that gender-affirming care is the only treatment option, (3) have a healthcare professional attest that the individual is suffering from "no other mental health concerns, including

93. *See Medicaid Coverage of Transgender-Related Health Care*, MOVEMENT ADVANCEMENT PROJECT (Mar. 14, 2025), https://www.lgbtmap.org/equality-maps/healthcare/medicaid.

94. Alabama, Arizona, Arkansas, Florida, Georgia, Idaho, Indiana, Iowa, Kentucky, Louisiana, Mississippi, Missouri, Montana, Nebraska, New Hampshire, North Carolina, North Dakota, Ohio, Oklahoma, South Carolina, South Dakota, Tennessee, Texas, Utah, West Virginia, and Wyoming. *See infra* Appendix. While this Article focuses on the state laws banning or restricting the provision of gender-affirming care, other state laws similarly prevent access to care. For example, at least seven states expressly prohibit Medicaid from covering gender-affirming care. WILLIAMS REPORT, *supra* note 16, at 14; MAP REPORT, *supra* note 17, at 2–3.

95. Hawaii, Kansas, Michigan, New Jersey, New Mexico, Oregon, Pennsylvania, Virginia, and Washington. *See* WILLIAMS REPORT, *supra* note 16, at 17; *infra* Appendix (updating with laws already passed).

96. S. 1138, 55th Leg., 2d Reg. Sess. (Ariz. 2022); H. 619, 2023 Leg., Reg. Sess. (N.H. 2023).

97. *See infra* Appendix.

98. Alabama, Florida, Georgia, Idaho, Indiana, Iowa, Kentucky, Louisiana, Mississippi, Missouri, Montana, North Carolina, North Dakota, Ohio, Oklahoma, South Carolina, South Dakota, Tennessee, Texas, and West Virginia. *See infra* Appendix.

99. Leg. 574, 108th Leg., Reg. Sess. (Neb. 2023); S. 16, 2023 Leg., Gen. Sess. (Utah 2023); H. 2007, 86th Leg., Reg. Sess. (W. Va. 2023); *see also infra* Appendix (explaining that Nebraska, Utah, and West Virginia ban all gender-affirming surgeries but only restrict access to gender-affirming medications).

100. Neb. Leg. 574; Utah S. 16; W. Va. H. 2007. For additional discussion, see *infra* Part II.C.

101. This is currently due, in part, to a federal court ruling halting the implementation of Arkansas' previous law, which was a complete ban of gender-affirming surgeries and medications. *See* Brandt v. Rutledge, 677 F. Supp. 3d 877, 925 (E.D. Ark. 2023).

102. S. 199, 94th Gen. Assemb., Reg. Sess. (Ark. 2023).

without limitation depression, eating disorders, autism, attention deficit hyperactivity disorder, intellectual disability, or psychotic disorders," (4) parental informed consent, and (5) be informed of certain risks of gender-affirming care as laid out in the statute.[103] Gender-affirming care is prohibited if the patient cannot meet these requirements.

These state laws include four major types of penalties.[104] First, at least seventeen state laws provide that healthcare professionals may have their licenses suspended or revoked due to providing gender-affirming care constituting "unprofessional conduct."[105] Second, at least sixteen states provide a private right for individuals against their healthcare professionals in addition to medical malpractice.[106] Relatedly, these laws also strengthen medical malpractice cases against providers, extending the statute of limitations[107] and, in some cases, allowing individuals to withdraw consent retroactively.[108] Third, attorneys general in at least five states may have enforcement authority to take civil actions against physicians.[109] These fines can be as high as $25,000 per violation.[110] Fourth, at least six states have implemented criminal penalties, characterizing some provision of gender-affirming care as a felony and punishing the provision of gender-affirming care with fines and/or incarceration of up to ten years.[111]

States and politicians justify these statutes as a means to protect children from unnecessary treatment. The treatments are commonly described as dangerous and experimental, subject to a lack of medical evidence.[112] Arkansas's

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103. *Id.*

104. *See infra* Appendix.

105. *Infra* Appendix; WILLIAMS REPORT, *supra* note 16, at 12–13. Such discipline can impact the status of providers' licenses in other states as well. *Cf.* Cohen et al., *supra* note 9, at 96–97 (discussing impact of the Interstate Medical Licensure Compact on abortion providers).

106. Mallory et al., *supra* note 17, at 1821–22; *cf. infra* Appendix (demonstrating that twelve states provide a private right of action for individuals against their healthcare professionals).

107. *See* WILLIAMS REPORT, *supra* note 16, at 12–13.

108. *See, e.g.*, S. 16, 2023 Leg., Gen. Sess. (Utah 2023).

109. Mallory et al., *supra* note 17, at 1821–22; *see infra* Appendix (listing four states where attorneys general may have enforcement authority to take civil actions against physicians).

110. *E.g.*, Mallory et al., *supra* note 17, at 1821–22 (discussing Tennessee's law); *see infra* Appendix (explaining Tennessee's law).

111. *See* Mallory et al., *supra* note 17, at 1821–22; *see infra* Appendix (listing five states that have implemented criminal penalties).

112. For more examples of this language, see S. 184, 2022 Leg., Reg. Sess. (Ala. 2022) ("This course of treatment for minors commonly begins with encouraging and assisting the child to socially transition to dressing and presenting as the opposite sex. In the case of prepubertal children, as puberty begins, doctors then administer long-acting GnRH agonist (puberty blockers) that suppress the pubertal development of the child. This use of puberty blockers for gender nonconforming children is experimental and not FDA-approved."); *id.* ("This unproven, poorly studied series of 9 interventions results in numerous harmful effects for minors, 10 as well as risks of effects simply unknown due to the new and 11 experimental nature of these interventions."); H. 648, 2023 Leg., Reg. Sess. (La. 2023) (titling the bill the "Stop Harming Our Kids Act"); H. 1125, 2023 Leg.,

law was titled the "Arkansas Save Adolescents From Experimentation ("SAFE") Act."[113] The Tennessee legislature's bill had a finding characterizing gender-affirming care as "experimental in nature and not supported by high-quality, long-term medical studies."[114] Some states also characterize gender dysphoria as a phase. For example, the Arkansas legislature wrote, "studies consistently demonstrate the majority come to identify with their biological sex in adolescence or adulthood . . . ."[115] Likewise, the Alabama law referred to gender dysphoria as something individuals will "outgrow."[116] Some laws undermine also patients' ability to understand the nature of their conditions. Alabama's statute, for example, says that minors and their parents are often "unable to comprehend and fully appreciate the risk and life implications" that result from gender-affirming care.[117] As opposed to protecting transgender individuals, these laws are limiting their access to—and choice regarding—medical care.

The state laws restricting gender-affirming care have far-reaching consequences. Almost one-third of transgender youth ages thirteen to seventeen live in states that ban or restrict gender-affirming care.[118] One study estimated that over one hundred and fifty thousand transgender youth live in states that have laws or pending bills banning or restricting gender-affirming care.[119] Not only do these laws ban gender-affirming care in their state they also make it very difficult for patients to access care out of state. A study of these bans found that a Florida minor would have to drive a median of nine hours to access gender-affirming care; in six other states, it would take a minor greater than five hours to access care.[120] Some states are also trying to make these laws apply

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Reg. Sess. (Miss. 2023) (titling the bill the "Regulate Experimental Adolescent Procedures (REAP) Act"); S. 49, 102d Gen. Assemb., Reg. Sess. (Mo. 2023) (titling the bill the "Missouri Save Adolescents from Experimentation (SAFE) Act"); H. 68, 135th Gen. Assemb., Reg. Sess. (Ohio 2023) (titling the bill the "Saving Ohio Adolescents from Experimentation (SAFE) Act"); S. 0001, 113th Gen. Assemb., Reg. Sess. (Tenn. 2023) ("[T]he legislature finds it likely that not all harmful effects associated with these types of medical procedures when performed on a minor are yet fully known, as many of these procedures, when performed on a minor for such purposes, are experimental in nature and not supported by high-quality, long-term medical studies."); *id.* ("This state has a legitimate, substantial, and compelling interest in encouraging minors to appreciate their sex, particularly as they undergo puberty. This state has a legitimate, substantial, and compelling interest in protecting the integrity of the medical profession, including by prohibiting medical procedures that are harmful, unethical, immoral, experimental, or unsupported by high-quality or long-term studies, or that might encourage minors to become disdainful of their sex.").

113. H. 1570, 93d Gen. Assemb., Reg. Sess. (Ark. 2021).

114. Tenn. S. 0001.

115. Ark. H. 1570.

116. Ala. S. 184.

117. *Id.*

118. *Bans on Best Practice Medical Care for Transgender Youth*, MOVEMENT ADVANCEMENT PROJECT (Mar. 16, 2025), https://www.lgbtmap.org/equality-maps/healthcare/youth_medical_care_bans.

119. WILIAMS REPORT, *supra* note 16, at 3.

120. Luca Borah, Laura Zebib, Hayley M. Sanders, Megan Lane, Daphna Stroumsa & Kevin C. Chung, *State Restrictions and Geographic Access to Gender-Affirming Care for Transgender Youth*, 330 JAMA 375, 376–77 (2023).

extraterritorially, prohibiting patients from receiving gender-affirming care out-of-state or prohibiting providers from assisting in providing gender-affirming care to an individual in that state. Iowa, for example, prohibits aiding or abetting youth accessing gender-affirming care.[121] While the constitutionality of these laws is unclear, similar laws have been implemented (and not yet challenged) in the abortion context.[122]

C. LITIGATION RELATED TO STATE LAWS ON GENDER-AFFIRMING CARE

Litigation has already begun against the state laws restricting gender-affirming care for minors.[123] Most cases have been based on violations of the United States Constitution and federal laws.[124] Plaintiffs in Alabama,[125] Arkansas,[126] Florida,[127] Idaho,[128] Indiana,[129] Oklahoma,[130] and Tennessee[131] have challenged their respective states' laws as violating the Equal Protection Clause and Due Process Clause of the Fourteenth Amendment.[132] The Equal Protection claims center on whether the state laws discriminate against transgender minors by prohibiting medically necessary services for them, while

121. IOWA CODE ANN. § 147.164 (West 2025).

122. *See* Leslie Francis & John Francis, *Federalism and the Right to Travel: Medical Aid in Dying and Abortion*, 26 J. HEALTH CARE L. & POL'Y 49, 59–63 (2023) (discussing extraterritorial application of state abortion laws); *accord* Cohen et al., supra note 9, at 27–52.

123. *See* WILIAMS REPORT, *supra* note 16, at 8–9; Dawson et al., *supra* note 12.

124. Some other cases have been brought under state constitutions. A Missouri circuit court judge declined to issue a preliminary injunction barring enforcement of the state's gender-affirming care law, finding plaintiffs had not shown a sufficient probability of success on their claims under the Missouri constitution's equal protection, due process, and natural rights clauses. Noe v. Parson, No. 23AC-CC04530 (Miss. Cole Cnty. Cir. Ct. Aug. 25, 2023) (order denying preliminary injunction). Other similar challenges are currently pending. In Montana, three families with transgender youth and two healthcare providers challenged the state law as violating rights under the Montana state constitution, including freedom of expression, equal protection rights, due process rights, privacy rights, dignity rights, and the right to seek health. Complaint at 4, Van Garderen v. Mont., No. DV-32-2023-0000541-CR (Mont. Dist. Ct. July 17, 2023). A Texas case similarly rested on state constitutional grounds, including parental autonomy rights, equal protection rights, and liberty rights. Petition for Declaratory Judgment at 45, 51, Loe v. Texas, No. D-1-GN-23-003616, 2023 WL 5519799 (Tex. Dist. Ct. Aug. 25, 2023); State v. Loe, 692 S.W.3d 215, 216–217 (Tex. 2024).

125. Eknes-Tucker v. Marshall, 603 F. Supp. 3d 1131, 1141 (M.D. Ala. 2022)), *vacated sub nom.* Eknes-Tucker v. Governor of Ala., 80 F.4th 1205 (Ala. 2023); U.S. CONST. amend. I; U.S. CONST. amend. V.

126. Brandt v. Rutledge, 677 F. Supp. 3d 877, 877 (E.D. Ark. 2023).

127. Doe v. Ladapo, 676 F. Supp. 3d 1205, 1209–10 (N.D. Fla. 2023), *appeal dismissed sub nom.* Doe v. Surgeon Gen., Fla., No. 23-12159-JJ, 2024 WL 5274658 (11th Cir. July 8, 2024).

128. Poe v. Labrador, 709 F. Supp. 3d 1169, 1178–80 (D. Idaho 2023), *appeal docketed*, No. 24-142 (9th Cir. Jan. 9, 2024).

129. K.C. v. Individual Members of Med. Licensing Bd. of Ind., 677 F. Supp. 3d 802, 806 (S.D. Ind. 2023) (challenging the law under the Medicaid Act and Affordable Care Act in addition to constitutional claims), *rev'd and vacated*, 121 F.4th 604 (7th Cir. 2024).

130. Poe v. Drummond, 697 F. Supp. 3d 1238, 1245–46 (N.D. Okla. 2023), *appeal docketed*, No. 23-5110 (10th Cir. Oct. 10, 2023).

131. L.W. v. Skrmetti, 83 F.4th 460, 460 (6th Cir. 2023), *cert. granted sub nom.* United States v. Skrmetti, 145 S. Ct. 411 (2024) (mem.).

132. U.S. CONST. amend. XIV, § 1.

permitting the same or similar treatments for cisgender minors.[133] The Due Process Clause claims focus instead on parents' rights and autonomy violated by the state law prohibitions of treatment they need for their child.[134]

Outcomes thus far have been mixed. Federal courts in Alabama,[135] Arkansas,[136] and Florida[137] issued injunctions against their respective state laws, finding plaintiffs had demonstrated a substantial likelihood of success on both Fourteenth Amendment claims and precluded enforcement of their bans on gender-affirming medications (and, in the case of Arkansas, gender-affirming surgeries as well). An Indiana court similarly issued a preliminary injunction, but only reviewed plaintiffs' equal protection claim.[138] Cases in Idaho[139] and Oklahoma[140] are still pending. In contrast, the United States Court of Appeals for the Sixth Circuit allowed Tennessee's law to go into effect.[141] It was argued before the Supreme Court on December 4, 2024.[142]

Gender-affirming care laws continue to be implemented and litigated, putting patients' access to gender-affirming care at risk. Even the passage of a state law may deter patients from seeking care, knowing their privacy may not be protected.[143] Some healthcare professionals are deterred from providing gender-affirming care. Washington University in St. Louis, for example, has ceased its provision of gender-affirming care to minors due to risks of legal liability.[144] As a result, these state laws also restrict access to FDA-approved medications. The majority of the litigation has focused on the discriminatory and

133. *See, e.g.*, Eknes-Tucker v. Marshall, 603 F. Supp. 3d 1131, 1146 (M.D. Ala. 2022) (holding that the Alabama gender-affirming care ban violates Plaintiffs' Fourteenth Amendment equal protection rights); Dawson et al., *supra* note 12 (reviewing the *Eknes-Tucker* case, among others).

134. *See, e.g.*, *Eknes-Tucker*, 603 F. Supp. 3d at 1144; Dawson et al., *supra* note 12.

135. *Eknes-Tucker*, 603 F. Supp. 3d at 1151.

136. Brandt v. Rutledge, 677 F. Supp. 3d 877, 925 (E.D. Ark. 2023). Note the Eighth Circuit had previously only reviewed plaintiffs' Equal Protection claims when reviewing a preliminary injunction appeal. *See* Brandt v. Rutledge, 47 F.4th 661, 672 (8th Cir. 2022).

137. Doe v. Ladapo, 676 F. Supp. 3d 1205, 1227 (N.D. Fla. 2023).

138. K.C. v. Individual Members of Med. Licensing Bd. of Ind., 677 F. Supp. 3d 802, 812–18 (S.D. Ind. 2023), *rev'd and vacated*, 121 F.4th 604 (7th Cir. 2024).

139. Poe v. Labrador, 709 F. Supp. 3d 1169 (D. Idaho 2023), *appeal docketed*, No. 24-142 (9th Cir. Jan. 9, 2024). *Poe v. Labrador*, ACLU (Feb. 21, 2025), https://www.aclu.org/cases/poe-v-labrador.

140. Poe v. Drummond, 697 F. Supp. 3d 1238 (N.D. Okla. 2023), *appeal docketed*, No. 23-5110 (10th Cir. Oct. 10, 2023); *Poe v. Drummond*, ACLU (Feb. 21, 2025), https://www.aclu.org/cases/poe-v-drummond.

141. L.W. v. Skrmetti, 83 F.4th 460, 491 (6th Cir. 2023), *cert. granted sub nom.* United States v. Skrmetti, 145 S. Ct. 411 (2024) (mem.).

142. *United States v. Skrmetti*, SCOTUSBLOG, https://www.scotusblog.com/case-files/cases/united-states-v-skrmetti (last visited Mar. 16, 2025).

143. *See, e.g.*, Hill L. Wolfe, Taylor L. Boyer, Jillian C. Shipherd, Michael R. Kauth, Guneet K. Jasuja & John R. Blosnich, *Barriers and Facilitators to Gender-affirming Hormone Therapy in the Veterans Health Administration*, 57 ANNALS OF BEHAV. MED. 1014, 1015 (2023) (citing data privacy concerns as a barrier to accessing gender-affirming care).

144. Virginia Hughes, *Washington University Stops Offering Gender Medications to Minors*, N.Y. TIMES (Sept. 11, 2023), https://www.nytimes.com/2023/09/11/health/transgender-minors-washington-university.html.

equal protection elements of these state laws. Litigants have thus far placed less attention on the implications of these state laws for FDA regulations and the role FDA does or could play in protecting equal access to gender-affirming care medications.

II. THE FDA, PREEMPTION, AND GENDER-AFFIRMING CARE MEDICATIONS

State laws banning or restricting the provision of gender-affirming care are largely not preempted by federal laws. Altogether, these laws highlight weaknesses in current federal regulations that states can exploit to restrict access to gender-affirming care. As new laws continue to be implemented and new cases challenge these laws, patients' access to gender-affirming care is left in a precarious position.

This Part looks at the interaction between state laws restricting gender-affirming care and the FDA's regulation of prescription drugs. This Part evaluates the scope of these regulations, their conflicts with state laws, and the challenges these interactions pose in protecting access to gender-affirming care. Subpart A begins with a primer on the FDA preemption doctrine. Subpart B describes the interaction between state laws restricting gender-affirming care and FDA regulations of off-label use. Subpart C considers the FDA's role in determining safety and effectiveness and the significance of the Risk Evaluation and Mitigation Strategy ("REMS") program in the preemption analysis.

A. PREEMPTION DOCTRINE

The FDA preemption doctrine and healthcare federalism go hand-in-hand. The FDA obtains its authority under the Commerce Clause, permitting it to regulate prescription drugs (among other products) in interstate commerce.[145] Most other healthcare regulations—particularly those related to the practice of medicine and tort law—are left to the states as part of their police powers.[146] Yet if Congress passes a law pursuant to its enumerated powers that conflicts with state law, the Constitution's Supremacy Clause dictates that federal law takes precedence and supersedes or "preempts" the state law.[147] The core of

145. JENNIFER A. STAMAN, CONG. RSCH. SERV., R43609, ENFORCEMENT OF THE FOOD, DRUG, AND COSMETIC ACT: SELECT LEGAL ISSUES 2 (2018) (citing Hipolite Egg Co. v. United States, 220 U.S. 45, 57 (1911)).

146. *See* Zettler, *Toward Coherent Federal Oversight*, *supra* note 2, at 430 (citing Dent v. West Virginia, 129 U.S. 114, 122–23, 128 (1889)).

147. U.S. CONST. art. VI, cl. 2. ("[The] Constitution, and the Laws of the United States which shall be made in Pursuance thereof; . . . shall be the supreme Law of the Land; and the Judges in every State shall be bound thereby, any Thing in the Constitution or Laws of any State to the Contrary notwithstanding."); *see also* Hillsborough Cnty. v. Automatic Med. Lab'ys, 471 U.S. 707, 714 (1985) ("It is a familiar and well-established principle that the Supremacy Clause . . . invalidates state laws that 'interfere with, or are contrary to,' federal law." (quoting Gibbons v. Ogden, 22 U.S. 1, 211 (1824)); Cipollone v. Liggett Grp., Inc., 505 U.S. 504, 516 (1992).

preemption is Congress's purpose—whether or not Congress intended federal law to displace state law and to be the sole authority regulating an area.[148]

There are two types of preemption: express preemption and implied preemption.[149] Express preemption is when a federal law contains a preemption clause stating it supersedes and displaces contrary state laws.[150] Implied preemption is further divided into two subcategories: field preemption and conflict preemption.[151] Field preemption occurs when a federal regulatory scheme pervasively occupies a field, so there is no room for states to regulate.[152] Conflict preemption occurs in two forms: (1) when an actor cannot comply with both federal and state regulations—impossibility preemption—or (2) when the state law poses an obstacle to or frustrates the purpose of federal regulations—obstacle preemption.[153]

The prescription drug section of the Federal Food, Drug, and Cosmetic Act ("FDCA") does not contain an explicit or express preemption provision[154] and has not been interpreted to constitute field preemption.[155] Therefore, preemption challenges must be brought under conflict preemption, either impossibility or obstacle preemption. Notable cases have been brought as a result of the tension between state tort law and FDA regulations. For example, in *Wyeth v. Levine*, the Supreme Court held that states could find a pharmaceutical manufacturer failed to warn patients of a risk under state tort law even though it had complied with FDA's labeling requirements, disagreeing with defendants' obstacle preemption theory.[156] Within the FDA's regulatory scheme, the *brand name* manufacturer could update the safety label and thus could have complied with both federal and state laws. In contrast, in *PLIVA v. Mensing*, states could not

148. Wyeth v. Levine, 555 U.S. 555, 565 (2009); *see also* Cohen et al., *supra* note 9, at 56–57 (citing Food and Drug Administration Modernization Act of 1997, Pub. L. No. 105–115, § 406(a), 111 Stat. 2296, 2369 (codified as amended at 21 U.S.C. § 393(b) (2018))); *What We Do*, FDA (Nov. 21, 2023), https://www.fda.gov/about-fda/what-we-do; PETER BARTON HUTT, RICHARD A. MERRILL & LEWIS A. GROSSMAN, FOOD AND DRUG LAW: CASES AND MATERIALS 2 (4th ed. 2013); 21 U.S.C. § 355–1(f)(2)(C).

149. BRYAN L. ADKINS, ALEXANDER H. PEPPER, & JAY B. SYKES, CONG. RSCH. SERV., R45825, FEDERAL PREEMPTION: A LEGAL PRIMER 2–3 (2023) [hereinafter FEDERAL PREEMPTION PRIMER]; Gade v. Nat'l Solid Wastes Mgmt. Ass'n, 505 U.S. 88, 98 (1992).

150. FEDERAL PREEMPTION PRIMER, *supra* note 149, at 2.

151. *Id.* at 2–3; *Gade*, 505 U.S. at 98.

152. FEDERAL PREEMPTION PRIMER, *supra* note 149; Arizona v. United States, 567 U.S. 387, 401 (2012).

153. FEDERAL PREEMPTION PRIMER, *supra* note 149; Fla. Lime & Avocado Growers, Inc. v. Paul, 373 U.S. 132, 142–43 (1963); Hines v. Davidowitz, 312 U.S. 52, 67 (1941).

154. Cohen et al., *supra* note 9, at 56 (citing Wyeth v. Levine, 555 U.S. 555, 567 (2009)); Zettler, *supra* note 5, at 868 ("Additionally, the language from the 1962 amendments to the FDCA preserving state authority except where it 'direct[ly] and positive[ly] conflict[s]' with those amendments, cited by the majority in *Wyeth*, provides evidence that Congress did not intend FDA approval decisions to preempt state bans on any theory other than impossibility." (alterations in original)).

155. *Cf. Wyeth*, 555 U.S. at 574–75 (stating that "Congress did not intend FDA oversight to be the exclusive means of ensuring drug safety and effectiveness" and left room for state tort and products liability claims).

156. *Id.* at 558.

find a *generic* manufacturer failed to warn patients of a risk under state tort law because it had complied with the FDA's labeling requirements, striking down the suit under impossibility preemption.[157] The Court's distinction here was the ability of the manufacturer to independently comply with the state and federal regulatory schemes. A *brand name* manufacturer could have notified FDA and updated its label due to newfound risks,[158] while *generic* manufacturers are required to track the brand name manufacturer's labeling and therefore could not both comply with FDA requirements and provide additional warnings under state law.[159] These and other related FDA preemption cases have demonstrated the value in displacing state laws, even those increasing the duty on certain parties. States cannot pass laws interfering with the generic drug labeling scheme, but they can keep measures providing patients with greater information and protection. Although the cause of action is not the state practice of medicine as could be raised in gender-affirming care cases, these cases reinforce courts' historically deferential attitude towards the FDA in what is needed in regulating prescription drugs.

Outside the FDA labeling context, preemption has also been raised as a challenge in state bans or restrictions on certain FDA-approved drugs.[160] In 2014, a Massachusetts state law banning an FDA-approved opioid, Zohydro (because it lacked abuse-deterrent properties), was invalidated.[161] Plaintiffs argued that the law, which set additional requirements for a physician to prescribe Zohydro, was preempted by FDA's regulations.[162] The district court agreed with the plaintiffs' preemption theory, saying if "the Commonwealth interprets its regulation to make Zohydro a last-resort opioid, it undeniably makes Zohydro less available."[163] The court, therefore, preliminarily enjoined enforcement of the state law.[164] Massachusetts then modified the law to restrict

157. PLIVA, Inc. v. Mensing, 564 U.S. 604, 608–09 (2011).

158. *Wyeth*, 555 U.S. at 568.

159. *PLIVA*, 564 U.S. at 614–17. Interestingly, in *Mutual Pharmaceutical Co. v. Bartlett*, the Supreme Court, in holding a state design defect claim against a generic manufacturer was preempted by FDA regulation due to impossibility, did not even mention obstacle preemption in the majority opinion. Mut. Pharm. Co. v. Bartlett, 570 U.S. 472, 476 (2013). It was mentioned, however, in the dissent's analysis. *See id.* at 494 (Breyer, J., dissenting); *see also id.* at 496–520 (Sotomayor, J., dissenting).

160. *See* Zogenix, Inc. v. Patrick, No. 14–11689–RWZ, 2014 WL 1454696, at *1 (D. Mass. Apr. 15, 2014) (Massachusetts ban of Zohydro); Complaint at 7–8, Bryant v. Stein, 732 F. Supp. 3d 485 (M.D.N.C. 2024) (No. 1:23-cv-00077) (North Carolina restrictions on mifepristone); Complaint at 30, Genbiopro, Inc. v. Sorsaia, No. 3:23-cv-0058, 2023 WL 5490179 (S.D. W. Va. Aug. 24, 2023) (West Virginia ban on abortion, including mifepristone); Complaint at 1, Genbiopro v. Dobbs, No. 3:20-cv-00652 (S.D. Miss. Oct. 9, 2020) (Mississippi restrictions on Mifepristone).

161. Zogenix, Inc. v. Patrick, No. 14–11689–RWZ, slip op. at 8 (D. Mass. July 7, 2014) ("[A]ssess[ing] whether the regulations prevent[ed] the accomplishment of the FDA's objective that safe and effective drugs be available to the public.").

162. *Id.*

163. *Id.* at 8–9.

164. *Zogenix*, 2014 WL 1454696, at *2.

instead of ban the drug.[165] While courts may be willing to support states' efforts to provide patients with stronger warnings, the Zohydro case indicates that courts may be less likely to second-guess the FDA's authority when it comes to permitting approved drugs to be sold.

Similar arguments have been raised in the context of mifepristone, one of the drugs used in a two-part medication abortion.[166] In a challenge to West Virginia's near-complete abortion ban, for example, plaintiffs argued that state laws on mifepristone were preempted because they "frustrate and conflict with" Congress's mandate that the FDA "determine that they are necessary for patient safety and will not unduly burden patient access."[167] The court disagreed. Writing in *GenBioPro, Inc. v. Sorsaia*, the West Virginia district court declined to apply obstacle preemption, instead using a general "conflict preemption" category in reviewing the restrictions applied to mifepristone.[168] Instead of reading the FDA's authority under the REMS program to preempt additional state-level safety requirements, the court looked to the history of the REMS program and Congress's consideration of simultaneous state laws restricting access to mifepristone at the time the laws were passed.[169] The court ultimately held that "[a]ny additional or incidental burden West Virginia has placed upon patients wishing to obtain mifepristone does not provide an unconstitutional 'obstacle' to the FDAAA's unambiguous directive to the FDA."[170]

A similar case was brought in North Carolina, which, by contrast, had mixed results.[171] In *Bryant v. Stein*, plaintiffs challenged state requirements that only physicians prescribe, dispense, and administer mifepristone in person, that

165. Zettler, *supra* note 5, at 873. The district court did not enjoin these new laws, although the judge said that "the preemption claim could succeed if the new regulations did, in fact, affect the availability of Zohydro, she declined to enjoin the new regulations." *Id.* (citing Zogenix, Inc. v. Baker, No. 14-11689-RWZ, 2015 WL 1206354, at *4 (D. Mass. Mar. 17, 2015)).

166. *See, e.g.*, Zettler et al., *Collateral Consequences*, *supra* note 9, at e29(1–3) (citing Complaint, Alliance for Hippocratic Medicine v. FDA, 668 F. Supp. 3d 507 (N.D. Tex. 2022) (No. CV-00223-Z)); Patricia J. Zettler & Ameet Sarpatwari, *State Restrictions on Mifepristone Access—the Case for Federal Preemption*, 86 NEW ENG. J. MED. 705, 705–07 (2023). *See generally* Zettler et al., *Mifepristone*, *supra* note 9 (reviewing preemption arguments to state law bans and restrictions on mifepristone).

167. Complaint at 5, GenBioPro, Inc. v. Sorsaia, No. 3:23-cv-0058, 2023 WL 5490179 (S.D. W. Va. Aug. 24, 2023). The DOJ had previously set the stage for these arguments, advising after *Dobbs* that FDA regulation preempts state laws restricting access to abortion medications. Press Release, Off. of Pub. Affs., U.S. Dep't of Just., Attorney General Merrick B. Garland Statement on Supreme Court Ruling in Dobbs v. Jackson Women's Health Organization (June 24, 2022), https://www.justice.gov/opa/pr/attorney-general-merrick-b-garland-statement-supreme-court-ruling-dobbs-v-jackson-women-s.

168. *Sorsaia*, 2023 WL 5490179, at *5 ("This Opinion considers both whether the challenged state provisions 'conflict' with or provide an 'obstacle' to federal law, treating these as one form of 'conflict' preemption, in accordance with e.g., [Murphy v. Nat'l Collegiate Athletic Ass'n, 138 S. Ct. 1461, 1480 (2018)].").

169. *Id.* at *6–8.

170. *Id.* at *8 (noting that FDAAA refers to the FDA Amendments Act).

171. Bryant v. Stein, 732 F. Supp. 3d 485, 513 (M.D.N.C. 2024), *judgment entered*, No. 1:23-cv-77, 2024 WL 3107568 (M.D.N.C. June 3, 2024), *appeal docketed*, No. 24-1617 (4th Cir. July 9, 2024)

specific in-person tests were completed, and that physicians report all adverse events to both the FDA and the state.[172] The court ultimately held that the state's physician-only, in-person prescribing, dispensing, and administering requirements, the follow-up appointment requirements, and the FDA reporting requirements were preempted.[173] Finding obstacle preemption based on the REMS program, the court wrote:

> The state here is imposing restrictions on who can prescribe a REMS drug and how that drug can be prescribed, dispensed, and administered. Those exact restrictions have been explicitly rejected by the FDA as unnecessary for safe administration and as unnecessary burdens on the health care system and patient access. They conflict with the clearly stated congressional goals of (1) having the FDA in charge of managing risks associated with REMS drugs, (2) limiting restrictions on REMS drugs to those necessary for safety purposes, and (3) avoiding restrictions that impose unnecessary burdens on the health care system and patient access.[174]

While the court determined that the in-person testing and state reporting requirements were permissible under the state's regulatory authority over the practice of medicine and public health, the decision demonstrates at least some courts' willingness to defer to the FDA's determinations on safety and effectiveness over state second-guessing.

Given the facts of the gender-affirming care restrictions, this Article focuses primarily on obstacle preemption in the FDA law context. Manufacturers are not prohibited from selling gender-affirming medications entirely, which would raise impossibility preemption because manufacturers' only alternative would be to stop selling their FDA-approved product.[175] Instead, as discussed later in this Article, state laws restrict the indications for which gender-affirming medications are prescribed by physicians and the manner in which they are administered. In this context, impossibility preemption would place responsibility related to off-label use of drugs on manufacturers—a responsibility that they do not currently possess, nor have they been suggested to have. Instead, the preemption analysis considers the extent to which the state laws frustrate the purpose of FDA regulation.

B. OFF-LABEL USE

Proponents of gender-affirming care could argue that these state laws are preempted by FDA law, as they restrict use of FDA-approved medications.

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172. *Id.* at 491.

173. *Id*. at 490.

174. *Id*. at 508.

175. *Cf.* Mut. Pharm. Co. v. Bartlett, 570 U.S. 472, 488 (2013) ("We reject this 'stop-selling' rationale as incompatible with our pre-emption jurisprudence.").

Similar to the mifepristone cases, these state laws are setting conditions, or effectively banning certain FDA-approved medications. However, there is a significant difference between these laws and other cases where states have restricted FDA-approved medications: the indications restricted. Indications of a drug are the medical conditions for which a drug is used to treat.[176] State abortion laws, for example, are restricting the use of mifepristone for its approved indication of terminating pregnancy.[177] The Massachusetts law restricting Zohydro applied to its approved indication for pain management.[178]

By contrast, the state laws restricting use of gender-affirming medications[179] do not apply to FDA-approved indications, as there are currently no FDA-approved medications for the treatment of gender dysphoria.[180] Puberty blockers are approved for precocious puberty, palliative treatment of advanced prostate cancer, and endometriosis.[181] Testosterone is only approved for "use in men who lack or have low testosterone levels in conjunction with an associated medical condition. . . . Examples . . . include failure of the testicles to produce testosterone because of reasons such as genetic problems or chemotherapy."[182] Estrogen is approved for restoring hormone levels in cisgender women, typically related to menopause.[183] Therefore, when prescribed for gender-affirming care, these drugs are all used off-label.[184]

The "off-label" use of gender-affirming care medications explains, in part, critics' characterization of gender-affirming care as "experimental" and

176. *See, e.g.*, *Drugs@FDA Glossary of Terms*, FDA (Nov. 14, 2017), https://www.fda.gov/drugs/drug-approvals-and-databases/drugsfda-glossary-terms (defining indication, under the definition of label, as "what the drug is used for."); Ryan Sila, Note, *Incentivizing Pharmaceutical Testing in an Age of Off-Label Promotion*, 93 N.Y.U. L. REV. 941, 946 (2018) (citing William S. Comanor & Jack Needleman, *The Law, Economics, and Medicine of Off-Label Prescribing*, 91 WASH. L. REV. 119, 120 (2016)); Christopher M. Wittich, Christopher M. Burkle & William L. Lanier, *Ten Common Questions (and Their Answers) About Off-Label Drug Use*, 87 MAYO CLINIC PROC. 982, 982 (2012).

177. Zettler et al., *Mifepristone*, *supra* note 9, 20–21; Complaint at 4, *Bryant*, 732 F. Supp. 3d 485 (No. 1:23-cv-00077) (North Carolina restrictions on mifepristone); Complaint at 3–4, GenBioPro, Inc. v. Sorsaia, No. 3:23-cv-0058, 2023 WL 5490179 (S.D. W. Va. Aug. 24, 2023) (West Virginia ban on abortion, including mifepristone).

178. *See* FDA, ZOHYDRO® ER 1 (Dec. 2016), https://www.accessdata.fda.gov/drugsatfda_docs/label/2016/202880s009s010lbl.pdf.

179. Some states ban both puberty blockers and hormone therapies, while others only ban hormone therapies, and twenty states ban the use of some or all gender-affirming medications: Alabama, Florida, Georgia, Idaho, Indiana, Iowa, Kentucky, Louisiana, Mississippi, Missouri, Montana, North Carolina, North Dakota, Ohio, Oklahoma, South Carolina, South Dakota, Tennessee, Texas, and West Virginia. *See infra* Appendix.

180. *See* Geffen et al., *supra* note 53.

181. *See* Akosua Mireku, *Legal Challenges Put Off Label Use of Gender Affirming Care Drugs in Jeopardy*, PHARM. TECH. (Mar. 16, 2023), https://www.pharmaceutical-technology.com/features/legal-challenges-put-off-label-use-of-gender-affirming-care-drugs-in-jeopardy.

182. *Testosterone Information*, FDA, (Feb. 28, 2025), https://www.fda.gov/drugs/postmarket-drug-safety-information-patients-and-providers/testosterone-information.

183. *See* Geffen et al., *supra* note 53; *Menopause & Hormones Common Questions*, *supra* note 65.

184. Geffen et al., *supra* note 53, at 42–43.

"unproven."[185] Experimental drugs, called "investigational new drugs" by the FDA, refer to drugs not yet reviewed and approved for a specific use.[186] Designation as an investigational new drug allows a manufacturer to begin clinical trials to test the safety and effectiveness of their drug in hopes of ultimately receiving FDA approval.[187] While an investigational new drug may be part of a clinical trial, it is not necessary that the use is specifically part of a clinical study.[188] Under the FDCA, the "investigational new drugs" label also applies to individual use of an approved drug for an indication which FDA has not approved,[189] including off-label use.[190] Despite the fact that physicians can prescribe medications for unapproved uses (off-label prescribing) and patients can take medications for unapproved uses (off-label use) without additional FDA approval, it is technically an "experimental" or "investigational" use.[191]

Yet, while critics still point to the unapproved nature of gender-affirming care medications, off-label prescribing and use of prescription drugs is very common.[192] Studies have estimated that off-label uses account for 20 percent of

185. *See, e.g.*, Selena Simmons-Duffin & Hilary Fung, *In Just a Few Years, Half of All States Passed Bans on Trans Health Care for Kids*, NPR (July 3, 2024, 6:00 AM EST) (quoting Matt Sharp, *We Must Protect Minors from Gender Transition Procedures*, ALL. DEFENDING FREEDOM (June 7, 2024), https://adflegal.org/article/we-must-protect-minors-gender-transition-procedures), https://www.npr.org/sections/shots-health-news/2024/07/03/nx-s1-4986385/trans-kids-health-bans-gender-affirming-care.

186. *Investigational New Drug (IND) Application*, FDA (May 6, 2020), https://www.fda.gov/drugs/types-applications/investigational-new-drug-ind-application; 21 C.F.R. § 312.20 (2025) ("A sponsor shall submit an IND to FDA if the sponsor intends to conduct a clinical investigation with an investigational new drug . . . .").

187. 21 C.F.R. § 312.20 (2025). This designation also permits individual patient use of the experimental drug in certain circumstances, including emergency use and compassionate use. *See* 21 C.F.R. § 312.310 (2025); *Right to Try*, FDA (Jan. 23, 2023), https://www.fda.gov/patients/learn-about-expanded-access-and-other-treatment-options/right-try. Such parallels incorrectly connect the use of gender-affirming care medications off-label to compassionate and experimental use of drugs, which were held not protected in *Abigail All. for Better Access to Developmental Drugs v. von Eschenbach*, 495 F.3d 695, 713 (D.C. Cir. 2007), *cert. denied*, 552 U.S. 1159 (2008) (holding patients have no right to "a potentially toxic drug with no proven therapeutic benefit," even in the case of terminal illness).

188. 21 C.F.R. § 312.3(b) (2025).

189. 21 C.F.R. § 312.3(b) (2025).

190. *Understanding Unapproved Use of Approved Drugs "Off Label,"* FDA (Feb. 5, 2018), https://www.fda.gov/patients/learn-about-expanded-access-and-other-treatment-options/understanding-unapproved-use-approved-drugs-label; *Off-Label Drugs: What You Need to Know*, AGENCY FOR HEALTHCARE RSCH. & QUALITY (Sept. 2015), https://www.ahrq.gov/patients-consumers/patient-involvement/off-label-drug-usage.html#:~:text=Off%2Dlabel%20prescribing%20is%20when,are%20for%20off%2Dlabel%20use.

191. *See* Ryan Knox, Note, *More Prices, More Problems: Challenging Indication-Specific Pricing as a Solution to Prescription Drug Spending in the United States*, 18 YALE J. HEALTH POL'Y, L., & ETHICS 191, 218 (2019) [hereinafter Knox, *Indication-Specific Pricing*]; George Horvath, *Off-Label Drug Risks: Toward a New FDA Regulatory Approach*, 29 ANNALS HEALTH L. & LIFE SCI. 101, 102 (2020).

192. *See* Knox, *Indication-Specific Pricing*, *supra* note 191, at 219; Horvath, *supra* note 191.

all prescriptions[193] and as high as 80 percent for some practice areas.[194] Off-label use is more common for certain populations,[195] including children[196] and pregnant people,[197] because they are generally excluded as clinical trial subjects and therefore not included in the FDA-approved indication.[198]

It is true that off-label uses usually have less evidence supporting their effectiveness than approved indications.[199] One estimate suggests that up to 79 percent of off-label uses "are not supported by strong clinical evidence."[200] Some studies have also found that off-label uses are associated with "significantly higher rates of adverse events than on-label uses . . . ."[201]

However, others are supported by decades of use and positive outcomes.[202] For example, aspirin was used off-label for the prevention of heart attack and

193. Knox, *Indication-Specific Pricing*, *supra* note 191, at 219; Katrina Furey & Kirsten Wilkins, *Prescribing "Off-Label": What Should a Physician Disclose?*, 18 AMA J. ETHICS 587, 588 (2016) (10 percent to 20 percent); Horvath, *supra* note 191 (twenty-one percent to fifty percent) (citing Aaron S. Kesselheim, *Off-Label Drug Use and Promotion: Balancing Public Health Goals and Commercial Speech*, 37 AM. J.L. & MED. 225, 234 (2011)).

194. Horvath, *supra* note 191 (some specialties as high as eighty percent, particularly oncology, neurology, and psychiatry).

195. *See also* Furey & Wilkins, *supra* note 193, at 589 ("Another reason that off-label prescribing is common is that there is limited evidence of the effectiveness of 'on-label' use in certain patient populations frequently excluded from clinical trials, such as children, pregnant women, the elderly, and psychiatric patients." (citing Wittich et al., *supra* note 176; Madlen Gazarian, Maria Kelly, John R. McPhee, Linda V. Graudins, Robyn L. Ward & Terence J. Campbell, *Off-label Use of Medicines: Consensus Recommendations for Evaluating Appropriateness*, 185 MED. J. AUSTRALIA 544, 544–48 (2006); April S. Fitzgerald & Patrick G. O'Malley, *Staying on Track When Prescribing Off-Label*, 89 AM. FAM. PHYSICIAN 4, 4–5 (2014)).

196. *See, e.g.*, Katelyn Yackey, Kristin Stukus, Daniel Cohen, David Kline, Sonia Zhao & Rachel Stanley, *Off-label Medication Prescribing Patterns in Pediatrics: An Update*, 9 HOSP. PEDIATRICS 186, 188 (2019); Divya Hoon, Matthew T. Taylor, Pooja Kapadia, Tobias Gerhard, Brian L. Strom & Daniel B. Horton, *Trends in Off-Label Drug Use in Ambulatory Settings: 2006–2015*, PEDIATRICS, Oct. 2019, at 1, 2; H. Christine Allen, M. Connor Garbe, Julie Lees, Naila Aziz, Hala Chaaban, Jamie L. Miller, Peter Johnson, Stephanie DeLeon, *Off-Label Medication Use in Children, More Common Than We Think: A Systematic Review of the Literature*, 111 J. OKLA. STATE MED. ASS'N 776, 776 (2018); Samir S. Shah et al., *Off-label Drug Use in Hospitalized Children*, 161 JAMA PEDIATRICS 282, 287 (2007).

197. Gail A. Van Norman, *Off-Label Use vs. Off-Label Marketing of Drugs*, 8 JACC BASIC TO TRANSLATIONAL SCI. 224, 226 (2023); Rieke van der Graaf, Indira S. E. der Zande, Hester M. den Ruijter, Martijn A. Oudijk, Johannes J. M. van Delden, Katrien Oude Rengerink & Rolf H. H. Groenwold, *Fair Inclusion of Pregnant Women in Clinical Trials: An Integrated Scientific and Ethical Approach*, TRIALS, Jan. 29, 2018, at 1, 2 ; Katrina Heyrana, Heather M. Byers & Pamela Stratton, *Increasing the Participation of Pregnant Women in Clinical Trials*, 320 JAMA 2077, 2077 (2018).

198. *See* Furey & Wilkins, *supra* note 193, at 589; Patricia J. Zettler, *The Indirect Consequences of Expanded Off-Label Promotion*, 78 OHIO STATE L.J. 1053, 1078 (2017) [hereinafter Zettler, *Off-Label Promotion*].

199. Zettler, *Off-Label Promotion*, *supra* note 198, at 1056; Horvath, *supra* note 191.

200. Horvath, *supra* note 191.

201. Zettler, *Off-Label Promotion*, *supra* note 198, at 1056.

202. *Cf.* AGATA BODIE, CONG. RSCH. SERV., R45792, OFF-LABEL USE OF PRESCRIPTION DRUGS 2–3 (2021) (discussing well-accepted off-label uses).

stroke as early as the 1950s.[203] Major studies supported its effectiveness in the 1970s and 1980s, but it was not approved for preventive use until 1998.[204] In oncology, rare diseases, and pediatrics, off-label use is oftentimes the accepted standard of care.[205]

Similarly, gender-affirming medications have been used for decades to treat gender dysphoria.[206] Gender-affirming medications and gender-affirming surgeries have been provided to transgender people since the 1930s.[207] Puberty blockers have been used for gender dysphoria since the 1990s.[208] Studies have found that gender-affirming care is associated with improved health outcomes, improved mental health, high satisfaction, and low rates of regret in both adults and minors.[209] Several national and international medical associations consider

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203. *See* Michael J. R. Desborough & David M. Keeling, *The Aspirin Story—From Willow to Wonder Drug*, 177 BRITISH J. HAEMATOLOGY 674, 679 (2017).

204. Internal Analgesic, Antipyretic, and Antirheumatic Drug Products for Over- The-Counter Human Use; Final Rule for Professional Labeling of Aspirin, Buffered Aspirin, and Aspirin in Combination with Antacid Drug Products, 63 Fed. Reg. 56802, 56812 (Oct. 23, 1998) (to be codified at 21 C.F.R. pt. 343) (explaining OTC monograph process adding primary prevention of heart attack and stroke as approved indications). However, since then, the U.S. Preventive Services Task Force has published new guidance no longer recommending aspirin for the treatment of heart disease. *See* Sandy Cohen, *Daily Aspirin No Longer Recommended to Prevent Heart Disease*, UCLA HEALTH (Apr. 26, 2022), https://www.uclahealth.org/news/article/daily-aspirin-no-longer-recommended-to-prevent-heart-disease.

205. *See, e.g.*, Zettler, *Off-Label Promotion*, *supra* note 198 (oncology); Rebecca Dresser & Joel Frader, *Off-Label Prescribing: A Call for Heightened Professional and Government Oversight*, 37 J.L., MED. & ETHICS 476, 476 (2009) (oncology, pediatrics, geriatrics, and obstetrics).

206. Nita Bhatt, Jesse Cannella & Julie P. Gentile, *Gender-affirming Care for Transgender Patients*, 19 INNOVATIONS CLINICAL NEUROSCIENCE 23, 29–30 (2022); Giordano & Holm, *supra* note 57, at 115.

207. Bhatt et al., *supra* note 206, at 29–31.

208. Giordano et al., *supra* note 57, at 113.

209. *See, e.g.*, David Matthew Doyle, Tom O.G. Lewis & Manuela Barreto, *A Systematic Review of Psychosocial Function Changes After Gender-Affirming Hormone Therapy Among Transgender People*, 7 NATURE HUM. BEHAV. 1320, 1327 (2023); Diane Chen, Johnny Berona, Yee-Ming Chan, Diane Ehrensaft, Robert Garofalo, Marco A. Hidalgo, Stephen M. Rosenthal, Amy C. Tishelman & Johanna Olson-Kennedy, *Psychosocial Functioning in Transgender Youth After 2 Years of Hormones*, 388 NEW ENG. J. MED. 240, 243 (2023); Diana M. Tordoff, Johnathon W. Wanta, Arin Collin, Cesalie Stepney, David J. Inwards-Breland & Kym Ahrens, *Mental Health Outcomes in Transgender and Nonbinary Youths Receiving Gender-Affirming Care*, JAMA NETWORK OPEN, Jan. 24, 2022, at 1, 7; Polly Carmichael, Gary Butler, Una Masic, Tim J. Cole, Bianca L. De Stavola, Sarah Davidson, Elin M. Skageberg, Sophie Khadr & Russell M. Viner, *Short-Term Outcomes of Pubertal Suppression in a Selected Cohort of 12 to 15 Year Old Young People with Persistent Gender Dysphoria in the UK*, PLOS ONE, Feb. 2, 2021, at 1, 18; Anthony N. Almazan & Alex S. Keuroghlian, *Association Between Gender-Affirming Surgeries and Mental Health Outcomes*, 156 JAMA SURGERY 611, 616 (2021); Chantal M. Wiepjes et al., *The Amsterdam Cohort of Gender Dysphoria Study (1972–2015): Trends in Prevalence, Treatment, and Regrets*, 15 J. SEXUAL MED. 582, 585 (2018); Jack L. Turban, Dana King, Jason J. Li &Alex S. Keuroghlian, *Timing of Social Transition for Transgender and Gender Diverse Youth, K-12 Harassment, and Adult Mental Health Outcomes*, 69 J. ADOLESCENT HEALTH 991, 996 (2021); Kristina R. Olson, Lily Durwood, Rachel Horton, Natalie M. Gallagher & Aaron Devor, *Gender Identity 5 Years After Social Transition*, PEDIATRICS, Aug. 1, 2022, at 1, 3. For a collection of 72 studies on gender-affirming care, see *"What Does the Scholarly Research Say about the Effect of Gender Transition on Transgender Well-Being?"* WHAT WE KNOW CORNELL UNIV., https://whatweknow.inequality.cornell.edu/topics/lgbt-equality/what-does-the-scholarly-research-say-about-the-well-being-of-transgender-people (last visited Mar. 1, 2025).

gender-affirming medications the standard of care.[210] The bulk of the evidence supports the safety and effectiveness of gender-affirming care.[211]

Despite this evidence supporting their safety and effectiveness, gender-affirming medications are still not FDA-approved for gender dysphoria. There are several reasons why they have not received approval for these indications. For one, manufacturers have little incentive to seek FDA approval for additional indications, especially in the context of gender-affirming medications. When a drug has multiple indications, manufacturers may wait to seek approval for additional indications until additional studies are completed, and later submit a supplemental New Drug Application.[212] Alternatively, manufacturers may choose to do nothing and continue to market their drug without modifying the label.[213] Since physicians can still prescribe an FDA-approved medication for an off-label use,[214] manufacturers have little reason to seek additional approvals. In the case of gender-affirming care, these drugs have been used for decades without approval; prior to these laws, nothing prevented physicians from prescribing gender-affirming medications off-label. With the political controversy surrounding gender-affirming care, manufacturers have further been deterred from seeking approval of their products for the treatment of gender dysphoria.[215] Conducting the trials to gain approval for gender dysphoria also presents practical and ethical challenges. As the drugs are already on the market, clinical trials represent an unnecessary expense for manufacturers and likely make it difficult to recruit participants as the patients already have access to the

210. *See, e.g.*, WPATH SOC, *supra* note 55 (providing clinical guidance for the treatment of people experiencing gender dysphoria); Heather Boerner, *What the Science on Gender-Affirming Care for Transgender Kids Really Shows*, SCI. AM. (May 12, 2022), https://www.scientificamerican.com/article/what-the-science-on-gender-affirming-care-for-transgender-kids-really-shows.

211. While my examination finds the bulk of the evidence is in support of the safety and effectiveness of gender-affirming care for minors, there are studies that have questioned the risk-benefit ratio or found little or no benefit from gender-affirming care. *See* Azeen Ghorayshi, *England Limits Use of Puberty-Blocking Drugs to Research Only*, N.Y. TIMES (June 12, 2023), https://www.nytimes.com/2023/06/09/health/puberty-blockers-transgender-children-britain-nhs.html; Joshua P. Cohen, *Increasing Number of European Nations Adopt A More Cautious Approach to Gender-Affirming Care Among Minors*, FORBES (June 14, 2023, 5:47 PM EDT), https://www.forbes.com/sites/joshuacohen/2023/06/06/increasing-number-of-european-nations-adopt-a-more-cautious-approach-to-gender-affirming-care-among-minors/?sh=403d3f8f7efb; NHS ENGLAND, CONSULTATION REPORT FOR THE INTERIM SERVICE SPECIFICATION FOR SPECIALIST GENDER INCONGRUENCE SERVICES FOR CHILDREN AND YOUNG PEOPLE 3 (2023), https://www.england.nhs.uk/wp-content/uploads/2023/06/Consultation-report-on-interim-service-specification-for-Specialist-Gender-Incongruence-Services-for-Children-.pdf. These studies, however, have not found harms associated with gender-affirming care that persuade it is not safe and requiring the bans and restrictions being implemented.

212. *See* Knox, *Indication-Specific Pricing*, *supra* note 191, at 217 (first citing 21 C.F.R. § 312 (2025) (investigational new drug application); and then 21 C.F.R. § 314 (2025) (discussing new drug application)).

213. Knox, *Indication-Specific Pricing*, *supra* note 191, at 217–19.

214. *See id.* at 219; Horvath, *supra* note 191.

215. Chad Terhune, Robin Respaut & Michelle Conlin, *As More Transgender Children Seek Medical Care, Families Confront Many Unknowns*, REUTERS INVESTIGATES (Oct. 6, 2022, 11:00 AM GMT), https://www.reuters.com/investigates/special-report/usa-transyouth-care.

treatment. Further, randomized clinical trials generally require a control group, which would likely be unethical given the mental health risks of withholding gender-affirming care.[216] These considerations are particularly salient for pediatric uses of these drugs, with trials being potentially unethical and off-label use being very common in pediatric populations.[217] Absent changes to the political environment and the trials required for approval, it is unlikely gender-affirming medications will be approved by FDA for these new indications, requiring continued off-label use.

In part because of the off-label use of gender-affirming care medications, state laws restricting access to gender-affirming care likely do not trigger conflict preemption.[218] Manufacturers can continue to sell their products and comply with state laws. It is not the manufacturers' sales of FDA-approved medications that these laws regulate; it is their subsequent prescribing and use. Manufacturers are still able to sell their FDA-approved drugs; even in the states with gender-affirming care bans, the laws only ban specific uses of the drugs.[219] The argument for preemption would be stronger if the drug were banned for all uses or its single FDA-approved indication, thereby second-guessing and completely overruling the FDA's determination the drug was safe and effective for the market.[220] Here, the FDA has not yet made a determination or officially spoken on the safety or effectiveness of gender-affirming medications for gender dysphoria.[221] Instead, these laws primarily regulate healthcare providers' decisions regarding prescribing of medications.

For FDA preemption to apply here, Congress would have had to express an intent for the FDA to play a greater role in the regulation of medicine.

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216. Theresa Gaffney, *Randomized Controlled Trials are the 'Gold Standard' of Research—but a Difficult Fit for Trans Care*, STAT NEWS (Sept. 15, 2023), https://www.statnews.com/2023/09/15/randomized-controlled-trials-gender-affirming-care. Some researchers have explored alternatives to traditional RCTs in studying the effectiveness of gender-affirming medications. *See, e.g.*, Brendan J. Nolan, Sav Zwickl, Peter Locke, Jeffrey D. Zajac & Ada S. Cheung, *Early Access to Testosterone Therapy in Transgender and Gender-Diverse Adults Seeking Masculinization: A Randomized Clinical Trial*, 6 JAMA NETWORK OPEN 1, 1 (2023).

217. Gaffney, *supra* note 216.

218. That being said, these laws present an unusual case. Beyond the few examples discussed herein, very few instances of off-label use prohibition have been identified. *See generally* Grossman, *supra* note 25 (collecting cases); Fox, *supra* note 47 (collecting examples). Other comparisons could be made with medical aid-in-dying, limiting uses of certain medications. Grossman, *supra* note 25 (collecting cases); Fox, *supra* note 47 (collecting examples).

219. *See infra* Appendix.

220. *See* Zettler et al., *Mifepristone*, *supra* note 9, at 19 (quoting Lars Noah, *State Affronts to Federal Primacy in the Licensure of Pharmaceutical Products*, 2016 MICH. ST. L. REV. 1, 12).

221. *Cf.* Geffen et al., *supra* note 53, at 42–43 (noting gender-affirming medications are used off-label). In recent years, the FDA has organized listening sections, convening groups to discuss the health challenges of transgender adults and minors. *See, e.g.*, *Joint Meeting of the FDA/CTTI Patient Engagement Collaborative (PEC) and EMA Patients and Consumers Working Party (PCWP)*, FDA 4 (July 1, 2021), https://www.fda.gov/media/150991/download.

Traditionally, the FDA does not regulate the practice of medicine.[222] Prescription drugs are approved and regulated by the federal government through its commerce powers.[223] States are left to regulate the practice of medicine through their police powers.[224] While in some cases the lines between the practice of medicine and drug regulation seem to be blurring,[225] Congress and the FDA have consistently reiterated that the FDA does not currently nor does it intend to regulate the practice of medicine.[226] Although having an incidental effect on FDA regulations, the state regulations on doctors' prescribing practices—either through bans or requirements—likely do not interfere with Congress's intent for FDA regulatory authority so as to trigger conflict preemption.[227]

State bans of gender-affirming care medications come closer to the traditional regulation of the practice of medicine than many of these earlier blurred line cases. Some of the state gender-affirming care statutes, for example, essentially ban off-label use by excluding gender-affirming care from the state's definition of medical practice.[228] These laws most directly affect a physician's decisionmaking—whether to prescribe a particular drug to a patient for a particular use—as opposed to affecting the marketing and use of the drug itself. They do not go so far as to "frustrate the purpose" of the FDA's approval of

222. *See, e.g.*, Zettler, *Toward Coherent Federal Oversight*, *supra* note 2, at 434–35; Legal Status of Approved Labeling for Prescription Drugs; Prescribing for Uses Unapproved by the FDA, 37 Fed. Reg. 16503, 16504 (proposed Aug. 15, 1972) ("[I]t is clear that Congress did not intend the [FDA] to regulate . . . the practice of medicine.").

223. STAMAN, *supra* note 145, at 6–7; Hipolite Egg Co. v. United States, 220 U.S. 45, 57 (1911).

224. *See* Gonzales v. Oregon, 546 U.S. 243, 270 (2006); Lewis, *Halted Innovation*, *supra* note 32, at 1077.

225. *See, e.g.*, Lewis, *Halted Innovation*, *supra* note 32, at 1089; Lewis, *Innovating Federalism*, *supra* note 32, at 387. The practice-product distinction has become increasingly unworkable, particularly in the context of innovative new medical technologies and FDA efforts to ensure safe use of certain products. *Id.* at 387. For example, in some cases, it has become unclear whether an FDA regulation targets the safety and effectiveness of a particular drug product or goes beyond that to regulate providers' prescribing and practices related to that medication or product. Professor Myrisha Lewis has argued that FDA's regulation of new innovative medical products, including stem cell therapies, CRISPR, and assisted reproductive technologies, is encroaching on state practice of medicine regulation. Lewis, *Halted Innovation*, *supra* note 32, at 1077. *Cf.* United States v. Regenerative Scis., LLC, 878 F. Supp. 2d 248, 255 (D.D.C. 2012), *aff'd*, 741 F.3d 1314 (D.C. Cir. 2014) (describing a stem cell therapy procedure). FDA law here can be viewed as regulating the manufacturing and use of a prescription drug or regulating a physician's personalized medicine procedure. Allison M. Whelan, *Aggravating Inequalities: State Regulation of Abortion and Contraception*, 46 HARV. J.L. & GENDER 131, 134–37 (2023) (collecting cases where FDA regulations implicitly or explicitly affect the practice of medicine); *see also* Mary Ann Chirba, *FDA Regulation of Stem Cell Therapies: Using a Stem Cell Fraud Strike Force to Separate Fact from Fiction*, 75 FOOD & DRUG L.J. 195, 220–30 (2020) (on the FDA regulation and state practice of medicine regulation in the context of stem cell therapies).

226. *See, e.g.*, *Regenerative Scis., LLC*, 878 F. Supp. 2d at 255; Wilhoit v. Boehringer Ingelheim Pharms., Inc., Nos. 07-MDL-1836, 08-CV-5755, 2009 WL 702007, at *3–4 (D. Minn. Mar. 13, 2009).

227. *Cf.* Lewis, *Innovating Federalism*, *supra* note 225, at 397 (citing statement of then-General Counsel of the FDA Peter Barton Hutt, in *Regulation of Diethylstilbestrol (DES) (Its Use as a Drug for Humans and in Animal Feeds): Hearings Before the Subcomm. of the H. Comm. on Gov't Operations*, 92d Cong. 103 (1971)).

228. *See infra* Appendix.

medications. Therefore, the current FDA preemption doctrine likely will not reach state laws on banning medications for gender-affirming care.

C. THE RISK EVALUATION AND MITIGATION STRATEGIES PROGRAM

FDA preemption may, however, reach state laws that set requirements on the use of FDA-approved medications, as opposed to imposing outright prohibitions; however, these arguments, are ultimately weakened by the off-label use of gender-affirming medications. The state requirements, though also arguably regulating the practice of medicine, are more related to current and largely accepted areas of FDA regulation. The most relevant are safety and effectiveness determinations and conditions of use set by the REMS program.

FDA approval of drugs considers both safety and efficacy.[229] In cases where the FDA has concerns about the safe use of a medicine, it may require additional measures related to the prescribing and administration of that medication.[230] These measures are issued as part of the REMS program.[231] A REMS may include medication guides, physician and patient communication plans, laboratory testing requirements, in-person dispensing requirements, restricted distribution of a drug through registered providers or specialty pharmacies, or patient enrollment in drug registries.[232] REMS are not commonly implemented, only applying to approximately five percent of FDA-approved drugs.[233]

The FDA's REMS authority provides a stronger argument for preemption of state restrictions on medication use. Under the Food and Drug Administration Amendments Act of 2007, Congress required the FDA to review drugs and determine whether, a REMS "is necessary to ensure that the benefits of the drug outweigh the risks of the drug" for post-approval safety.[234] The REMS may "not

229. *See* 21 U.S.C. § 393(b)(2)(C).

230. *See* 21 U.S.C. § 355–1 (discussing Risk Evaluation and Mitigation Strategies provision).

231. *See* 21 U.S.C. § 355–1; *Risk Evaluation and Mitigation Strategies | REMS*, FDA (May 16, 2023), https://www.fda.gov/drugs/drug-safety-and-availability/risk-evaluation-and-mitigation-strategies-rems.

232. *What's in a REMS?*, FDA (Jan. 26, 2018), https://www.fda.gov/drugs/risk-evaluation-and-mitigation-strategies-rems/whats-rems#:~:text=REMS%20include%20a%20risk%20mitigation,dispense%20or%20take%20the%20medication; Zettler et al., *Mifepristone*, *supra* note 9, at 8–9; Cohen et al., *supra* note 9, at 54.

233. *See* Greer Donley, *Medication Abortion Exceptionalism*, 107 CORNELL L. REV. 627, 640 (2022) (citing Mifeprex REMS Study Grp., *Sixteen Years of Overregulation: Time to Unburden Mifeprex*, 376 NEW ENG. J. MED. 790, 790 (2017)); Cohen et al., *supra* note 9, at 54 ("The imposition of a REMS is a rare action that, by statute, can only be imposed if a REMS is necessary to ensure that the drug's benefits outweigh its risks.").

234. 21 U.S.C. § 355–1(a)(1); *see also* Zettler et al., *Mifepristone*, *supra* note 9, at 8 ("FDAAA amended the FDCA to give FDA the statutory power to require that manufacturers institute REMS for prescription drugs if necessary to ensure the benefits of a drug outweigh the risks."); Cohen et al., *supra* note 9, at 57 ("When Congress created the REMS program in 2007, it gave the FDA the ability to impose additional controls on certain approved drugs but, in doing so, required the agency to use the least restrictive means of protecting the public.").

be unduly burdensome on patient access to the drug."[235] Thus, in evaluating a drug, the FDA determines what is necessary for its safe use and then sets requirements to ensure that safety. REMS represent the FDA's deliberation as to what is needed to ensure safe use, especially as they are required so infrequently.[236] Additional state requirements inconsistent with FDA determinations undermine Congress's intent to provide the FDA with the authority to review medications for safety and effectiveness and set approval requirements. State second-guessing of safety restrictions frustrates the purpose of the FDA's careful review to determine the least restrictive requirements needed for safe and effective use of a drug.[237]

State laws requiring restrictions on the use of gender-affirming medications may run afoul of FDA's determinations on what is necessary for safety, including REMS for some medications. At least one gender-affirming medication, (testosterone undecanoate, Aveed®),[238] has a currently approved REMS. These requirements are to mitigate the risk of anaphylaxis—completely unrelated to the requirements states have set on gender-affirming medications that require additional provider visits and notifications about purported risks. As the requirements set forth by these state laws are inconsistent with those the FDA has identified to ensure the drug is used safely, FDA law may preempt conflicting state restrictions on this gender-affirming medication. In similar cases regarding mifepristone, courts have reached mixed results as to whether the REMS program preempted the inconsistent state requirements, but some precedent exists for such a conflict preemption argument.[239] For other gender-affirming medications, the FDA's decision not to implement a REMS could also support preemption as the additional requirements are inconsistent with the FDA's determination. Congress has intended the FDA to be the sole agency determining what is necessary for the safe use of medications. States infringe on the FDA's authority in making these decisions, and thus these restrictions more broadly may be preempted by FDA regulations.

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235. 21 U.S.C. § 355–1(f)(5)(B). Some scholars have used this language to argue an intent for FDA to also ensure access to the drugs with REMS approved. *See* Zettler, *supra* note 5, at 875; Zettler et al., *supra* note 166, at 706.

236. *Cf.* Cohen et al., *supra* note 9, at 56–57.

237. *Cf.* Zettler et al., *Mifepristone*, *supra* note 9, at 19; Lars Noah, *Preempting Red State Restrictions on the Use of FDA-Approved Drugs in Gender-Affirming Care?*, 2024 UTAH L. REV. 833, 836–40.

238. *See generally, e.g.*, *Risk Evaluation and Mitigation Strategy (REMS) Document: Part A. Aveed REMS Program*, FDA (May 2022), https://www.accessdata.fda.gov/drugsatfda_docs/rems/Aveed_2022_05_26_REMS_Document.pdf (describing Aveed document's analysis of the risk of anaphylaxis); Cécile A. Unger, *Hormone Therapy for Transgender Patients*, 5 TRANSLATIONAL ANDROLOGY & UROLOGY 877, 878 (2016) (indicating Aveed can be used off-label for gender-affirming care).

239. Bryant v. Stein, 732 F. Supp. 3d 485 (M.D.N.C. 2024); GenBioPro, Inc. v. Sorsaia, No. 3:23-cv-0058, 2023 WL 5490179 (S.D. W. Va. Aug. 24, 2023).

That being said, only approved uses—not off-label uses—are considered by the FDA when developing REMS. The FDA does not make approval decisions related to off-label uses, and therefore their determinations on what is necessary for safe and effective use of a drug, including what is included in a REMS, are unrelated to these off-label uses.[240] The risks of a drug used on-label may be vastly different than when used off-label, especially in the case where the indications and populations are so different as they are in gender-affirming care.[241] Despite the evidence on the benefits of gender-affirming medications from real-world practice, it is possible that the FDA would determine there are additional safety concerns related to gender-affirming care. While the FDA is the designated decision-maker related to the safe use of medications, the FDA has not made a decision here. Prescribing medications is still within the practice of medicine and state law jurisdiction, allowing states to set restrictions on medications' use. FDA preemption, therefore, likely does not reach state bans and restrictions of gender-affirming medications—REMS or no REMS—because of their off-label usage.[242]

III. THE FDA'S ROLE IN ACCESS TO GENDER-AFFIRMING CARE MEDICATIONS

FDA laws and regulations do not preempt state laws banning or restricting access to gender-affirming care for minors. To protect patients' access to gender-affirming care medications, an expansion of the FDA's authority over prescription drug regulation is necessary. This could take the form of greater preemptive authority, superseding more state laws regulating prescription drugs or the FDA being the sole regulator in the context of pharmaceuticals. Alternatively, this could look like greater authority, complementing state public health powers, where the FDA implements programs and pathways to directly support patient access to medicines.

But before considering what form these reforms should take, it is important to find the right balance between state public health and FDA regulations. As the previous Part identified, the line between state and federal jurisdiction over health is not always clear and raises concerns regarding principles of federalism and health policy. Keeping this in mind, as well as the normative implications of expanding the scope of the FDA's authority, this Part considers what further role the FDA could play in protecting access to gender-affirming care

240. *What's in a REMS?*, *supra* note 232; *see also* Ryan Abbott & Ian Ayres, *Evidence and Extrapolation: Mechanisms for Regulating Off-Label Uses Of Drugs and Devices*, 64 DUKE L.J. 377, 388 (2014) (discussing how REMS could be used in relation to off-label uses).

241. *See* Mireku, *supra* note 181 (listing the FDA-approved indications of gender-affirming medications).

242. This is consistent with other commentators on related issues. *See* Grossman, *supra* note 25, at 305; Noah, *supra* note 237.

medications, as well as other medications subject to additional state law restrictions.

Subpart A explores the role of the FDA as a consumer protection agency, an innovation agency, and an access to medicines agency. Subpart B evaluates the risks and benefits of expanding the FDA's authority in the context of healthcare federalism and federalization. Subpart C raises two solutions that allow the FDA to play a greater role in protecting access to gender-affirming medications. First, Congress could amend the FDCA to contain an express preemption provision, allowing it to supersede contrary safety and efficacy determinations under state law. Second, Congress could create a new accelerated approval pathway to support the addition of off-label uses to the drug's approved label. Ultimately, this Part argues that both solutions would significantly promote access to medicines and allow the FDA to be an active participant in protecting access to gender-affirming care medications and other treatments.

A. THE ROLE OF THE FDA IN ACCESS TO MEDICINES: PAST, PRESENT, AND FUTURE

To understand the modern role of the FDA and consider its potential role in access to medicines, it is important to take into account the historical purposes and authorities of the agency. The FDA was founded with dual roles as a public health agency and a consumer protection agency.[243] In 1906, the Pure Food and Drug Act was passed, prohibiting the manufacture, sale, or transportation of "adulterated" foods in interstate commerce.[244] It protected public health by both requiring products to meet stated strength, quality, and purity standards and protected consumers by requiring truthful and non-misleading labeling.[245] The FDA's public health powers strengthened greatly in the following years. In 1938, the Food, Drug, and Cosmetic Act was signed, giving the FDA pre-market approval powers over drugs and the ability to require labeling to direct safe use.[246] This authority was expanded to include the power to require proof of the efficacy of drugs for pre-market approval with the Kefauver-Harris Amendments of 1962.[247] The next decades saw the addition of medical devices

243. *See, e.g.*, *Milestones in Food & Drug Law*, FDA (Jan. 30, 2023), https://www.fda.gov/about-fda/fda-history/milestones-us-food-and-drug-law; Andrea T. Borchers, Frank Hagie, Carl L. Keen & M. Eric Gershwin, *The History and Contemporary Challenges of the US Food and Drug Administration*, 29 CLINICAL THERAPEUTICS 1, 1 (2007).

244. *See Part I: The 1906 Food and Drugs Act and Its Enforcement*, FDA (Apr. 24, 2019), https://www.fda.gov/about-fda/changes-science-law-and-regulatory-authorities/part-i-1906-food-and-drugs-act-and-its-enforcement.

245. *Id.*

246. *See Part II: 1938, Food, Drug, Cosmetic Act*, FDA (Nov. 27, 2018), https://www.fda.gov/about-fda/changes-science-law-and-regulatory-authorities/part-ii-1938-food-drug-cosmetic-act.

247. *See* Jeremy A. Green & Scott H. Podolsky, *Reform, Regulation, and Pharmaceuticals—The Kefauver-Harris Amendments at 50*, 367 NEW ENGLAND J. MED. 1481, 1481 (2012).

to the FDA's regulatory purview (1976) as well as a range of nondrug products and systems, including vitamins and minerals (1976), nutritional labeling (1990), dietary supplements (1994), and tobacco (2009).[248] These key milestones represented an expansion of the FDA's role as a consumer protection agency focused on protecting the public health.

Other changes to the FDA's work, while related to protecting public health, have been more tangentially related to its traditional mission. That is to say that over time, the role of the FDA and the factors that contribute to its decision-making have expanded. As Professors Rachel Sachs, Nicholson Price, and Patricia Zettler have persuasively argued, the FDA has grown increasingly involved in innovation-related judgments.[249] While some of these are more controversial and have influenced other safety and effectiveness decisions,[250] others have been explicitly or implicitly authorized by Congress.[251] Beyond the agency's role in shaping innovation incentives as a whole—determining what drugs make it to market and therefore are profitable innovation investments—the FDA also routinely makes decisions regarding granting orphan drug designations, Priority Review Vouchers, and breakthrough drug designations, among other accelerated programs.[252] Each of these programs requires the FDA to consider some Congressionally guided innovation incentives in the drug review and approval processes beyond the safety and effectiveness of an existing or potential product.[253] For example, the FDA may determine if a drug is a novel treatment or an improvement upon existing treatments for diseases—thus worthy of additional regulatory exclusivities[254]—or if the drug is promising enough and fills a gap in available medical treatments to constitute a "breakthrough."[255] Whether active or ministerial, this takes the role of the FDA beyond consumer protection and public health to include influencing the creation of the pharmaceutical market.

Can this—and should this—be taken a step further? Has Congress implied or even authorized the FDA to take steps to promote access to medicines to patients? Many of these innovation programs are designed with the express purpose of increasing the development of, and therefore the access to, certain

248. *See, e.g.*, *Milestones in Food & Drug Law*, FDA (Jan. 30, 2023), https://www.fda.gov/about-fda/fda-history/milestones-us-food-and-drug-law.

249. *See generally* Sachs et al., *supra* note 2 (arguing for the FDA's role as an innovation agency).

250. *Id.* at 516–18.

251. *Id.* at 529–39.

252. *See id.*

253. *See id.*

254. *See id.*

255. *See id.* at 542.

types of medications.[256] Benefits for drugs treating rare diseases, neglected tropical diseases, and diseases where there is an unmet need all fill important demands from an access to medicines perspective. Despite its limitations, the expanded access program gives the FDA authority to make decisions that will directly affect patient access to medicines they otherwise would not be able to get.[257] And perhaps most directly, both the Hatch-Waxman program for generic development and the Biosimilar Price Competition and Innovation Act for biosimilar development created pathways for the FDA to oversee the creation of competitor products with the goal of greater affordability and accessibility.[258]

However, the FDA has been a more passive agency with regard to these "innovation-focused" and "access-focused" programs. The FDA does play a role in informing generic and biosimilar companies when patent protections for brand-name drugs, permitting generics and biosimilars to seek FDA approval and enter the market.[259] However, in most cases, the FDA is not actively soliciting applicants for generic and biosimilar products.[260] It reviews applications for rare diseases and other drugs when received and provides guidance to support and promote their development,[261] but is not in control of the actual applications it will receive from the pipeline. It also reviews compassionate use requests,[262] though the ultimate decision is left to the individual pharmaceutical company.

Perhaps the better model for the FDA as an access agency is the Over-the-Counter ("OTC") drug program.[263] Most drugs are initially approved as prescription drugs, meaning patients require a prescription from a doctor to

256. *See generally* FDA, GUIDANCE FOR INDUSTRY: EXPEDITED PROGRAMS FOR SERIOUS CONDITIONS—DRUGS AND BIOLOGICS (2014) (outlining four FDA programs intended to facilitate and expedite development and review of new drugs to address unmet medical need in the treatment of serious or life threatening conditions: fast track designation, breakthrough therapy designation, accelerated approval, and priority review designation).

257. Jonathan J. Darrow, Ameet Sarpatwari, Jerry Avorn & Aaron S. Kesselheim, *Practical, Legal, and Ethical Issues in Expanded Access to Investigational Drugs*, 372 NEW ENG. J. MED. 279, 279 (2015). The Expanded Access program is sometimes referred to as "compassionate use. *See Expanded Access*, FDA (Feb. 28, 2024), https://www.fda.gov/news-events/public-health-focus/expanded-access.

258. Drug Price Competition and Patent Term Restoration Act of 1984, Pub. L. No. 98–417, 98 Stat. 1585 (codified as amended in scattered sections of titles 15, 21, 35, and 42 of the U.S.C.); Biologics Price Competition and Innovation Act of 2009 ("BPCIA"), Pub. L. No. 111–148, 124 Stat. 804 (codified as amended at 42 U.S.C. § 262).

259. This is accomplished through publishing certain relevant patents in the Orange Book (for generics) and the Purple Book (for biosimilars). *See, e.g.*, Robin Feldman & Gideon Schor, *Purple is the New Orange: A Comparison of Competitive Information (?) in Generics and Biologics*, 2024 U. ILL. L. REV. 1075, 1101; Michael A. Carrier & Carl J. Minniti III, *Biologics: The New Antitrust Frontier*, 2018 U. ILL. L. REV. 1, 3.

260. There are some instances in the context of pediatrics, specifically under Pediatric Research Equity Act and the Best Pharmaceuticals for Children Act, where the FDA may solicit generic applications.

261. *See Rare Diseases at FDA*, FDA (Nov. 21, 2024), https://www.fda.gov/patients/rare-diseases-fda.

262. *See Expanded Access*, *supra* note 257.

263. *See Over-the-Counter OTC | Nonprescription Drugs*, FDA (June 20, 2023), https://www.fda.gov/drugs/how-drugs-are-developed-and-approved/over-counter-otc-nonprescription-drugs.

obtain the drug and cannot just choose to purchase it at the pharmacy.[264] With experience, however, some drugs are deemed to be safe for patients to use without the supervision of a doctor. The FDA can review an existing prescription drug and, if it determines that prescription "requirements are not necessary for the protection of the public health by reason of the drug's toxicity or other potentiality for harmful effect, or the method of its use, or the collateral measures necessary to its use, and [the FDA] finds that the drug is safe and effective for use in self-medication as directed in proposed labeling."[265] These decisions can be made after an application by manufacturers, initiated by a citizen's petition, or made through an administrative process indicated by the FDA itself.[266] In most cases however, these actions are initiated by manufacturers; for example, in 2023, the FDA approved applications from generic manufacturers to grant OTC-status to both Narcan (naloxone), a treatment to reverse opioid overdoses, and Opill (norgestrel), an oral contraceptive.[267]

Still, the FDA is authorized to directly take actions that will increase the accessibility of medications, although its considerations are primarily related to safety and toxicity.[268] Further, designating a prescription drug as OTC gives the FDA greater power over states' restrictions because of an express preemption provision. The FDCA provision states that "no State . . . may establish or continue in effect any requirement . . . which is different from or in addition to" those requirements set forth by the FDA.[269] This greatly restricts the ability of states to implement contrary safety or labeling requirements, thus greatly increasing accessibility and decreasing barriers for patients to access their medications.

Additionally, supporting switches of drugs from prescription status to OTC can further increase access to medicines by improving affordability. One study found that patient out-of-pocket costs for naloxone in North Carolina decreased over 30 percent (from an average of $90.93 to $62.67) after the first OTC formulation of naloxone entered the market.[270] By promoting more drugs being

264. *See* Lewis A. Grossman, *Freedom Not to See a Doctor: The Path Toward Over-The-Counter Abortion Pills*, 2023 WIS. L. REV. 1041, 1051–63.

265. 21 C.F.R. § 310.200(b) (2025).

266. *OTC Drug Review Process | OTC Drug Monographs*, FDA (Oct. 19, 2023), https://www.fda.gov/drugs/otc-drug-review-process-otc-drug-monographs.

267. *See* Press Release, FDA, FDA Approves First Over-the-Counter Naloxone Nasal Spray (Mar. 29, 2023), https://www.fda.gov/news-events/press-announcements/fda-approves-first-over-counter-naloxone-nasal-spray; Press Release, FDA, FDA Approves First Nonprescription Daily Oral Contraceptive (July 13, 2023), https://www.fda.gov/news-events/press-announcements/fda-approves-first-nonprescription-daily-oral-contraceptive.

268. Grossman, *supra* note 264.

269. 21 U.S.C. § 360k(a)(1).

270. Grace T. Marley, Izabela E. Annis, Kathleen L. Egan, Paul Delamater & Delesha M. Carpenter, *Naloxone Availability and Cost After Transition to an Over-the-Counter Product*, 5 JAMA HEALTH F. 1, 6 (2024).

approved as OTC, the FDA can take a more direct role in improving both access and the affordability of medicines.

It is apparent that the FDA already has some role in promoting access to medicines, albeit indirect. In order to strengthen the FDA's authority to actively promote and protect access to medications, like gender-affirming care medications, Congress would likely need to expand the FDA's federal reach. Thus, the two competing government regulatory structures—federalization and federalism—must be considered.

B. FEDERALISM CONSIDERATIONS IN EXPANDED FDA AUTHORITY

The U.S. Constitution divides powers between the single federal and many state governments.[271] As a result, any increase to the FDA's authority must both fall within the federal government's powers (oftentimes called "enumerated powers"[272]) and be balanced against any decrease in states' rights. In the case of expanding the FDA's authority over access to medicines, the first requirement is met: the FDA can regulate drugs as part of the federal government's commerce clause powers. The second requirement necessitates a further analysis of the benefits of federalism and federalization, discussed in turn here.

1. Benefits of Expanded Federalization in Drug Regulation

Although there is a presumption for decentralization in the federalist system, if there are strong benefits for federal regulation, the presumption of decentralization may be "overcome . . . by demonstrating the potential benefits of federal intervention in a specific instance" and "one strong merit may be sufficient to 'tip' the scales in favor of federal regulation."[273] Three key justifications for increased federalization support an expansion of the FDA's authority over prescription drugs: a national issue, regulatory efficiency, and benefits of uniformity. Each suggests great benefits for expanded FDA authority over prescription drug regulation.

First, as a general principle, federalism maintains a role for federal regulation when an issue is national in nature.[274] For example, federal regulation is advantageous in addressing problems that cross state lines or have interstate

271. KEVIN J. HICKEY, BRYAN L. ADKINS, WHITNEY K. NOVAK & JAY B. SYKES, CONG. RSCH. SERV., FEDERALISM-BASED LIMITATIONS ON CONGRESSIONAL POWER: AN OVERVIEW 1 (2023).

272. U.S. CONST. art. I, § 1; U.S. CONST. art. I, § 8.

273. Zettler, *Toward Coherent Federal Oversight*, *supra* note 2, at 479 (quoting Jonathan H. Adler, *Cooperation, Commandeering, or Crowding Out?: Federal Intervention and State Choices in Health Care Policy*, 20 KAN. J.L. & PUB. POL'Y 199, 205 (2011); and then citing Amy L. Stein, *The Tipping Point of Federalism*, 45 CONN. L. REV. 217, 227 (2012)).

274. Robert R.M. Verchick & Nina A. Mendelson, *Preemption and Theories of Federalism*, *in* PREEMPTION CHOICE: THE THEORY, LAW, AND REALITY OF FEDERALISM'S CORE QUESTION 13, 18–19 (W. Buzbee ed., 2009).

externalities, such as regulation of the water supply.[275] Prescription drugs are a national, and in many cases international, industry.[276] Permitting a patchwork of state standards for pharmaceutical companies to navigate increases the difficulty and complexity of compliance, a cost likely passed on to consumers. This is one of the justifications for preemption of contrary state labeling requirements for brand, generic, and OTC drugs.[277] The public health risks are also national in nature. The FDA was created because of claims that certain drugs were harming people. Varied safety standards across the country could put patients at risk of dangerous side effects from drugs subject to inadequate oversight.

Second, in some cases, federal regulation may also be more efficient, saving resources so that multiple levels of government do not make duplicative efforts to develop regulations.[278] Increased efficiency can also occur when the federal government has greater resources or expertise to address a certain issue.[279] Given both the regulatory expertise and the size of the pharmaceutical industry, the FDA is best positioned to most efficiently oversee it. Further, in addition to the complexity that can be posed by large state markets like California, many smaller states will not have the resources to conduct similar oversight. More centralized prescription drugs can lead to greater equity and an ability for expert agencies to reach consensus.

Perhaps foremost, federal regulation is most appropriate when seeking to provide uniformity in regulation, like in the case of prescription drug approvals or energy emissions,[280] or individual rights and benefits, like social security or health privacy.[281] Uniformity in regulation is particularly important in the case of the FDA to allow for consistency and predictability in determinations of safety and efficacy in the pharmaceutical market.[282] Further, in cases where public health and individual rights are at stake—as seen in the COVID-19

275. *Id.*

276. *See* IQVIA, GLOBAL USE OF MEDICINES 2024: OUTLOOK TO 2028, at 57–58 (2024), https://www.iqvia.com/-/media/iqvia/pdfs/china/viewpoints/iqvia-institute-general-use-of-medicines-2024-for-print.pdf.

277. Wyeth v. Levine, 555 U.S. 555, 565 (2009); PLIVA, Inc. v. Mensing, 564 U.S. 604, 639 (2011); Grossman, *supra* note 264, at 1098.

278. Verchick & Mendelson, *supra* note 274, at 18.

279. Zettler, *Toward Coherent Federal Oversight*, *supra* note 2, at 478–79 (citing Robert Glicksman & Richard E. Levy, *A Collective Action Perspective on Ceiling Preemption by Federal Environmental Regulation: The Case of Global Climate Change*, 102 NW. U. L. REV. 579, 594–600 (2008); and then Amy L. Stein, *The Tipping Point of Federalism*, 45 CONN. L. REV. 217, 227 (2012)).

280. Zettler, *Toward Coherent Federal Oversight*, *supra* note 2, at 473; Verchick & Mendelson, *supra* note 274, at 18.

281. Verchick & Mendelson, *supra* note 274, at 18.

282. Some scholars have pushed back, pointing to benefits in state pharmaceutical laws. For example, Professor Patricia Zettler has emphasized the value of uniformity in prescription drug regulation while also arguing that state experimentation, even if ultimately preempted, can spur federal policy advancement. Zettler, *supra* note 5, at 892–900.

pandemic response, abortion rights after *Dobbs*, and access to gender-affirming care—federalism has been a barrier to federal action and federal protection of individual liberty interests.[283] This limitation of healthcare federalism is also arising today, with patients having different access to medications and different healthcare coverage rights depending on their location and residence. In order to support the uniformity of regulation and rights consistent with the healthcare system, greater centralization of prescription drug regulation and expanded power for the FDA seem justified.

2. Responding to Criticisms of Expanded Federalization in Drug Regulation

Despite the strong arguments for centralization, the presumption continues to be for decentralization, maximizing the power left to the states. There are three key justifications for federalism both in healthcare and beyond, some raising important limitations to reforms providing the FDA with greater authority.

The first key justification for federalism is that it decreases the likelihood of federal tyranny by allocating certain powers to the states and leaving the state governments as a check on federal power.[284] Expanding FDA authority over state prescription drug regulations would significantly centralize power. While the FDA has been the primary agency in charge of prescription drugs, heightening its preemptive reach would limit states' involvement. Depending on the scope of the FDA's authority, states could be virtually cut out of decisions regarding the safe use of medicines. In many cases, this greater centralization is beneficial, supporting uniformity in safety and effectiveness standards. But there are two notable risks to such a regulatory design. First, what if the FDA's determination is ultimately found to be inadequate or harmful? If the FDA gets it wrong, greater centralization can lead to uniform, bad standards that put patients at risk. Limiting state authority removes an important check on the powers of the FDA. This also curtails the ability of the states to exercise their police powers to protect the public health as it relates to drug regulations. Second, greater centralization allows stakeholders, particularly the pharmaceutical industry, to focus lobbying efforts more narrowly. This can lead to risks of regulatory capture, where the FDA's decisions are heavily influenced and effectively controlled by industry, leading to a regulatory system more beneficial to industry and less focused on the intent of promoting patient access. The FDA needs to be able to make independent decisions based on the science

283. James G. Hodge, Jr., Summer Ghaith & Lauren Krumholz, *Federalism's Fallacy at the Forefront of Public Health Law*, 50 J.L., MED. & ETHICS 848, 850 (2022); Cary Coglianese, *Pandemic Federalism*, 68 WAYNE L. REV. 1, 3 (2022).

284. *See, e.g.*, Erwin Chemerinsky, *The Values of Federalism*, 47 FLA. L. REV. 499, 525–33 (1995).

and the data submitted by drug applicants. If regulatory capture leads to decisions that are bad for public health, greater centralization promotes non-interference by the states. In situations where decisions are non-politicized, the risks related to federal tyranny and regulatory capture are lower. Yet, when issues are highly politicized and controversial, as is the case with gender-affirming care medications, the risk of tyrannical, politics-based decision-making not necessarily related to the science can be substantial.

The second justification for federalism is the idea that state governments are closer to the citizens and thus may be more responsive to local needs.[285] When there are local public health challenges, increasing the powers held at the state and local level allow governments to be more proactive in implementing policy changes. This was observed during the opioid epidemic, where various interventions responding to the safe use of opioids were implemented at the state and city level. Given the different cultural attitudes towards certain types of medications and medical care across the country, ensuring that states can respond appropriately is invaluable to public health responses. State governments being more responsive to local needs can also be seen in the speed of regulations being implemented. Federal regulations may be slower to change, and the FDA may be slower to respond than state laws and governments.[286] In some cases where there are rapid developments in medical practice or drug safety, the FDA may not be the fastest actor to respond in terms of widespread reform. That being said, most issues related to prescription drugs will be uniform and national in nature, and the FDA held a centralizing role in collecting data on adverse events, overseeing post-market data collection, and notifying the public of recalls, newfound risks, and shortages.[287] Maximizing the benefits of the FDA's centrality can help state and local governments respond to concerns with up-to-date information, as opposed to the incomplete information and communications observed during the COVID-19 pandemic.[288] Further, in cases where variations in regulations can hinder public health responses and have national consequences, also seen during the COVID-19 pandemic, there is a

285. *Id.* at 527.

286. *Cf. id.*

287. *See, e.g.*, *FDA Adverse Event Reporting System (FAERS) Public Dashboard*, FDA (Dec. 7, 2023), https://www.fda.gov/drugs/fdas-adverse-event-reporting-system-faers/fda-adverse-event-reporting-system-faers-public-dashboard (adverse event reporting); *Postmarketing Surveillance Programs*, FDA (Apr. 2, 2020), https://www.fda.gov/drugs/surveillance/postmarketing-surveillance-programs (post-marketing surveillance); *Recalls, Market Withdrawals, & Safety Alerts*, FDA (Mar. 21, 2025), https://www.fda.gov/safety/recalls-market-withdrawals-safety-alerts; *Drug Shortages*, FDA (Mar. 13, 2025), https://www.fda.gov/drugs/drug-safety-and-availability/drug-shortages.

288. *See, e.g.*, Jordan Paradise & Elise Fester, *FDA Publicity and Enforcement in the COVID-19 Era*, 60 WASHBURN L.J. 77, 78 (2020); Maria Mercedes Ferreira Caceres et. al., *The Impact of Misinformation on the COVID-19 Pandemic*, 9 AIMS PUB. HEALTH 262, 264 (2022).

strong justification for greater federal regulatory authority overshadowing the costs to state and local responses.

Third, federalism's goals include state governments acting as laboratories of democracy and experimenting with new, innovative policies.[289] Such experimentation and innovation may also "accommodate cultural and local diversity that would be threatened by national uniformity."[290] Allowing for greater state experimentation can allow states to test different policies and gather more information on what is best to ensure a drug is safe and effective. However, state experimentation undermines the goals of providing uniform, equitable access to medicines across the country. In particular, state experimentation restricting access to certain drugs exacerbates the existing inequities in access to prescription drugs and access to healthcare more generally. Here, the goals of uniformity and access tend to outweigh the benefits associated with state experimentation.

With the goal of maintaining the FDA's role as prescription drug regulator and adding this Article's goal of increasing the FDA's role in promoting access to medicines, the benefits of greater federal authority over prescription drugs tend to outweigh the potential costs to state regulation. Reforms expanding the FDA's authority over drug regulation, either through greater preemption or other new powers, should be strongly considered.

C. FDA SOLUTIONS TO ACCESS TO GENDER-AFFIRMING CARE MEDICATIONS

Several FDA-focused solutions could be implemented to promote access to gender-affirming care medications and other medications more broadly in certain circumstances. This Subpart proposes two solutions—a preemption solution and a special approval pathway solution—and evaluates their potential to improve and protect access to medicines.

1. A Preemption Solution

First, Congress could expand the FDA's authority by amending the FDCA to add a preemption provision for prescription drugs. Congress has implemented preemption provisions for other areas under the FDA's purview, including medical devices and OTC medications, preventing states from interfering with FDA regulations.[291] This would follow the trends in FDA law, with greater preemption of state prescription drug laws and track proposals by other

289. Chemerinsky, *supra* note 284, at 528.

290. Zettler, *Toward Coherent Federal Oversight*, *supra* note 2, at 478 (citing Gregory v. Ashcroft, 501 U.S. 452, 458 (1991); Barry Friedman, *Valuing Federalism*, 82 MINN. L. REV. 317, 401–02 (1997); Michael W. McConnell, Review, *Federalism: Evaluating the Founders' Design*, 54 U. CHI. L REV. 1484, 1493 (1987)).

291. *See* 21 U.S.C. § 360k(a); *cf.* Riegel v. Medtronic, Inc., 552 U.S. 312, 315 (2008).

scholars.[292] Additionally, this would strengthen the FDA's ability to set the safety and effectiveness standards for medications, with or without considering off-label uses or the imposition of REMS.[293]

Preemption may be the simplest legislative solution, although there remains the question of exactly what state conduct should be preempted. The preemption provision could broadly preempt regulation in the field of prescription drugs or more narrowly delineate certain circumstances where FDA regulations would preempt state laws.[294] Although a broader preemption would have the benefit of limiting significant state action, it may also have unintended and unwanted consequences. The current FDA preemption doctrine leaves room for the states to regulate certain aspects related to prescription drugs, including tort liability and matters related to pharmacy and medical practice.[295] The FDA has long expressed its desire to stay out of regulating the practice of medicine,[296] and too broad a provision, particularly if it applied to off-label prescribing specifically, could put the FDA beyond its intended and desired regulatory reach. Further, a provision that is too broad could affect innovation and drug approval incentives in ways that do not benefit patients. If FDA law preempts state drug regulations even in the case of off-label use, what incentivizes manufacturers to seek additional approvals? Off-label prescribing already minimizes the need for manufacturers to gain approval for off-label indications.[297] Greater preemption could effectively treat the FDA approval as an any-use approval, with only restrictions for off-label promotion. This could decrease incentives for research into new indications, especially pediatric indications, thereby decreasing the evidence available on the effectiveness of drugs.

A narrower preemption provision, therefore, would likely be more appropriate. Congress could, for example, prohibit states from banning FDA-approved medications or implementing requirements that are contrary to or different from those set forth by the FDA's evaluation of safety and effectiveness.[298] While still relatively broad, such a preemption provision would more clearly limit state action and be consistent with the FDA's authority over prescription drug review. Alternatively, Congress could preempt states from placing additional regulations on certain medications, as it effectively does in the case of OTC medications. For example, a federal law could preempt bans or restrictions on gender-affirming medications and mifepristone while permitting

292. *See, e.g.*, Whelan, *supra* note 225, at 187–97.
293. *See supra* Subpart.II.A.
294. Whelan, *supra* note 225, at 198.
295. *See* Wyeth v. Levine, 555 U.S. 555, 565 (2009); PLIVA, Inc. v. Mensing, 564 U.S. 604, 609 (2011).
296. Zettler, *Toward Coherent Federal Oversight*, *supra* note 2, at 446.
297. *See* Knox, *Indication-Specific Pricing*, *supra* note 191, at 219.
298. *See supra* Subpart.II.A.

state laws relating to opioids and glucagon-like peptide 1 ("GLP-1") analogs like Ozempic (semaglutide). While mitigating some of the unintended consequences in a very broad preemption provision, this would be a more inefficient regulatory process, specifically in the context of a drug-by-drug model, and more vulnerable to regulatory capture concerns.[299] Other risks remain regarding the reach of FDA regulation into the practice of medicine, particularly related to off-label use and prescribing of drugs. And despite the benefits of a narrower preemption provision, any preemption provision will likely be challenged in the courts. The FDA preemption jurisprudence has already produced some confusing and seemingly inconsistent case law, and choosing a narrower provision open to greater interpretation may add to the murkiness of the current doctrine.[300] Lawmakers would have to consider this balance in order to adequately protect access to medicines across the country.

2. A Special Approval Pathway Solution

While much of this Article has focused on the FDA's preemptive reach and interaction with state law, preemption is by no means the only way to expand the FDA's authority to allow the FDA to take greater action in protecting access to medicines. A repeated barrier observed in the FDA's ability to influence access has been the off-label prescribing and use overlapping with states' powers to regulate medical practice. Circumventing that challenge, particularly in the case of protecting access to gender-affirming care medications, would be essential in allowing the FDA to fill this role.

To accomplish this, Congress could expand the FDA's authority to amend the approvals of already-approved medications without an application from the original sponsor. Generally, changes to the labels and approvals of prescription drugs must be submitted to the FDA by the original manufacturer or sponsor (through a supplemental New Drug Application).[301] This has been one reason why gender-affirming care medications have not been approved to treat gender dysphoria; the drugs' manufacturers lack the incentive or political will to do so.[302] Generic manufacturers are largely unable to seek additional indications or other label changes, and they, too, have no strong incentive to make the

299. *See generally* Allison M. Whelan, *Executive Capture of Agency Decisionmaking*, 75 VAND. L. REV. 1787 (2022) (on regulatory capture in pharmaceuticals).

300. *See, e.g.*, *PLIVA, Inc.*, 564 U.S. at 627 (2011) ("The Court gets one thing right: This outcome 'makes little sense.'").

301. 21 U.S.C. § 355 (generic drug sNDA provisions).

302. Terhune et al., *supra* note 215 (saying that manufacturers decline to seek approval of their drugs for gender-dysphoria because it would "cost a lot of money to get approval" and it is a "political hot potato"). *But see* Kevin Dunleavy, *Texas Launches Investigation of AbbVie, Endo for Alleged Off-Label Promotion of Puberty Blocking Drugs*, FIERCE PHARMA (Dec. 14, 2021, 4:00 PM), https://www.fiercepharma.com/pharma/texas-launches-investigation-abbvie-endo-for-improperly-promoting-puberty-blocking-drugs (arguing manufacturers are promoting their drugs off-label for gender-affirming care).

investment to do so. Creating a means for third parties—including patient advocates, professional organizations, and academic institutions—to request specific labeling changes to FDA-approved medications could resolve this problem. Third-party involvement would not be entirely unheard of in the FDA context. Third parties can seek changes in the OTC monograph process.[303] This was seen with the labeling changes to Narcan (naloxone), with hundreds of comments submitted to the agency for input.[304] The FDA also accepts citizen petitions, in which third parties can ask the FDA to "issue, amend, or revoke a regulation or order" or "take or refrain from taking any other form of administrative action."[305]

A new approval pathway could be particularly valuable in safety changes but may need additional reforms for new indications. Unlike the OTC monograph process, where third parties comment on how a drug can be used safely and effectively without oversight of a healthcare provider,[306] this pathway would likely—and should—require data supporting the drug's effectiveness. Given the availability of the drug on the market and its ability to be used off-label, it would be difficult and improper to conduct a randomized control trial.[307] Patients would have no incentive to participate in the study and denying the placebo group treatment would be unethical. Single arm trials could be conducted, as in the case of accelerated approval drugs, but the recruitment issue would remain. The FDA has grown more open to the use of real-world evidence—clinical evidence generated from the use of medical products in a patient setting—to support drug approvals and required it in some circumstances.[308] Historically, the use of real-world evidence to support effectiveness has been limited.[309] Guidance supporting approvals on the basis of real-world evidence would be necessary to make such a pathway feasible and practical.

Politically, such a pathway might be difficult for Congress to implement. Pharmaceutical companies are very protective of their prescription drugs, and even more so in the case of patented blockbuster medications. If third parties were able to seek approval for new indications when exclusivity protections still

303. *See* GOV'T ACCOUNTABILITY OFF., GAO-23-106570, OVER-THE-COUNTER DRUGS: STATUS OF FDA'S IMPLEMENTATION OF EXCLUSIVITY PROVISIONS IN THE CARES ACT 2 (2023).

304. Safety and Effectiveness of Certain Naloxone Hydrochloride Drug Products for Nonprescription Use; Request for Comments, 87 Fed. Reg. 68702, 68702 (Nov. 16, 2022).

305. 21 C.F.R. §§ 10.25, 10.30 (2025); *see also* Michael Carrier & Daryl Wander, *Citizens Petitions: An Empirical Study*, 34 CARDOZO L. REV. 249, 251–52 (2012).

306. *See OTC Drug Review Process | OTC Drug Monographs*, *supra* note 266.

307. Christopher M. Wittich, Christopher M. Burkle & William L. Lanier, *Ten Common Questions (and Their Answers) About Off-label Drug Use*, 87 MAYO CLINICAL PROC. 982, 982 (2012).

308. *Real World Evidence*, FDA (Sept. 19, 2024), https://www.fda.gov/science-research/science-and-research-special-topics/real-world-evidence.

309. *Id.*

applied, this could raise difficult patent and property rights issues beyond the scope of this discussion. For certain politically controversial medications, like mifepristone and gender-affirming care medications, companies may be averse to third parties being able to gain approval for some indications. Generally, for off-patent medications, however, this new pathway could be impactful in generating new evidence and approvals for prescription drugs and promoting access for patients.

CONCLUSION

Despite the federal government holding significant authority over prescription drugs, FDA regulations do not preempt state laws banning or restricting access to gender-affirming care medications. As lawmakers across the country seek to target transgender and non-binary minors and adults, steps must be taken to secure access to gender-affirming care. The FDA has the potential, with expanded powers, to take an active role in promoting and protecting access to medicines, either by preempting restrictive state laws or approving new indications for existing drugs. Ultimately, the proposals in this Article seek to maximize the regulatory authority already harnessed at the FDA and to put forth the FDA as an agency strongly situated to protect and promote access to medicines across the country.

APPENDIX

STATE LAWS RESTRICTING GENDER-AFFIRMING CARE[310]

STATE	PROHIBITIONS	PENALTIES
1. Alabama[311]	• Bans providers from performing gender-affirming surgeries or administering puberty blockers or hormone therapy to patients under age nineteen	• Felony
2. Arizona[312]	• Bans providers from performing gender-affirming surgeries for patients under age eighteen	• N/A (not included)
3. Arkansas[313] *(Enforcement permanently enjoined by federal court)*	• Restricts providers from performing gender-affirming surgeries or administering puberty blockers or hormone therapy to patients under age eighteen	• Private right of action • Attorney general enforcement

310. Status of legislation updated as of January 2025. For the status of additional laws and bills targeting the transgender community, including gender-affirming care, see *Bans On Best Practice Medical Care For Transgender Youth*, *supra* note 118; *2023 What Anti-Trans Bills Passed in 2023?*, TRANS LEGIS. TRACKER, https://translegislation.com/bills/2023/passed (last visited Mar. 24, 2025); *2025 Anti-Trans Bills Tracker*, *supra* note 17; *Snapshot: LGBTQ Equality By State*, MOVEMENT ADVANCEMENT PROJECT (Feb. 26, 2025), https://www.lgbtmap.org/equality-maps.

311. S. 184, 2022 Leg., Reg. Sess. (Ala. 2022).

312. S. 1138, 55th Gen. Assemb., 2d Reg. Sess. (Ariz. 2022).

313. S. 199, 94th Gen. Assemb., Reg. Sess. (Ark. 2023).

STATE	PROHIBITIONS	PENALTIES
4. Florida[314]	• Bans providers from performing gender-affirming surgeries or administering hormone therapy to patients under age eighteen • Bans non-physicians from providing gender-affirming care • Emergency child custody if patient is "being subjected to or threatened with being subjected to" gender-affirming care	• Felony: Up to five years imprisonment (providers) • Suspended license (providers) • Civil damages
5. Georgia[315]	• Bans providers from performing gender-affirming surgeries or administering hormone therapy to patients under age eighteen	• Administrative accountability to medical board
6. Idaho[316]	• Bans providers from performing gender-affirming surgeries or administering puberty blockers or hormone therapy to patients under age eighteen	• Felony • Up to ten years imprisonment • Fine up to $5,000
7. Indiana[317]	• Bans providers from performing gender-affirming surgeries or administering puberty blockers or hormone therapy to patients under age eighteen	• Private action for actual or threatened violations

314. S. 254, 2023 Leg., 125th Reg. Sess. (Fla. 2023).
315. S. 140, 157th Gen. Assemb., Reg. Sess. (Ga. 2023).
316. H. 71, 67th Leg., Reg. Sess. (Idaho 2023).
317. S. 480, 123d Gen. Assemb., Reg. Sess. (Ind. 2023).

STATE	PROHIBITIONS	PENALTIES
8. Iowa[318]	• Bans providers from performing gender-affirming surgeries or administering puberty blockers or hormone therapy to patients under age eighteen	• Discipline by the medical board • Private action for actual or threatened violations • Attorney general enforcement
9. Kentucky[319]	• Bans providers from performing gender-affirming surgeries or administering puberty blockers or hormone therapy to patients under age eighteen	• License revocation • Private Action
10. Louisiana[320]	• Bans providers from performing gender-affirming surgeries or administering puberty blockers or hormone therapy to patients under age eighteen	• License revocation (two year minimum) • Cause of action for damages • Attorney General enforcement
11. Mississippi[321]	• Bans providers from performing gender-affirming surgeries or administering puberty blockers or hormone therapy to patients under age eighteen	• License revocation • Individuals can seek "compensatory damages, injunctive relief, declaratory relief, or any other appropriate relief" for actual or threatened violations

318. S. 538, 90th Gen, Assemb., Reg. Sess. (Iowa 2023).
319. S. 150, 2023 Gen. Assemb., Reg. Sess. (Ky. 2023).
320. H. 648, 2023 Leg., Reg. Sess. (La. 2023).
321. H. 1125, 2023 Leg., Reg. Sess. (Miss. 2023).

STATE	PROHIBITIONS	PENALTIES
12. Missouri[322] *(Effective August 28, 2023 through August 28, 2027)*	• Bans providers from performing gender-affirming surgeries or administering puberty blockers or hormone therapy to patients under age eighteen	• Physicians: Loss of Medical Licensure • Parents or Guardians: Reported to social services for abuse or neglect • Patients may obtain financial compensation
13. Montana[323] *(Temporarily blocked by federal court order)*	• Bans providers from performing gender-affirming surgeries or administering puberty blockers or hormone therapy to patients under age eighteen	• Discipline from medical board with a mandatory one year suspension • Private action for damages and equitable relief
14. Nebraska[324]	• Bans providers from performing gender-affirming surgeries for patients under age nineteen • Restrictions on administering puberty blockers or hormone therapy to patients under age nineteen	• License revocation • Private action against healthcare professional
15. New Hampshire[325]	• Bans providers from performing gender-affirming surgeries for patients under age eighteen	• License revocation • Private action against healthcare professional

322. S. 49, 102nd Gen. Assemb., Reg. Sess. (Mo. 2023).
323. S. 99, 68th Leg., Reg. Sess. (Mont. 2023).
324. Leg. 574, 108th Leg., Reg. Sess. (Neb. 2023).
325. H. 619, 2023 Leg., Reg. Sess. (N.H. 2023).

STATE	PROHIBITIONS	PENALTIES
16. North Carolina[326]	• Bans providers from performing gender-affirming surgeries or administering puberty blockers or hormone therapy to patients under age eighteen	• Disciplinary proceedings • Private action against the healthcare provider
17. North Dakota[327]	• Bans providers from performing gender-affirming surgeries or administering puberty blockers or hormone therapy to patients under age eighteen	• Felony (gender-affirming surgeries); Misdemeanor (gender-affirming medications)
18. Ohio[328]	• Bans providers from performing gender-affirming surgeries or administering puberty blockers or hormone therapy to patients under age eighteen	• Disciplinary conduct • Private right of action • Attorney General enforcement

326. H. 808, Gen. Assemb., Reg. Sess. (N.C. 2023).

327. H. 1254, 68th Legis. Assemb., Reg. Sess. (N.D. 2023).

328. H. 68, 135th Gen. Assemb., Reg. Sess. (Ohio 2023); Shiela Smith, *House Bill 68: Pathway to Court*, ACLU OHIO (Mar. 18, 2025, 7:00 AM), https://www.acluohio.org/en/news/house-bill-68-pathway-court.

STATE	PROHIBITIONS	PENALTIES
19. Oklahoma[329] *(Not currently enforced by the Oklahoma Attorney General's Office, pending resolution of legal challenges)*	• Bans providers from performing gender-affirming surgeries or administering puberty blockers or hormone therapy to patients under age eighteen	• Disciplinary proceedings before the medical board, including suspension or revocation of license • Felony • Private right of action for actual or threatened violations
20. South Carolina[330]	• Bans providers from performing gender-affirming surgeries or administering puberty blockers or hormone therapy to patients under age eighteen	• Private right of action • Attorney General enforcement
21. South Dakota[331]	• Bans providers from performing gender-affirming surgeries or administering puberty blockers or hormone therapy to patients under age eighteen	• License revocation

329. S. 613, 59th Leg., Reg. Sess. (Okla. 2023).
330. H. 4624, 125th Leg., Reg. Sess. (S.C. 2023).
331. H. 1080, 98th Leg., Reg. Sess. (S.D. 2023).

STATE	PROHIBITIONS	PENALTIES
22. Tennessee[332]	• Bans providers from performing gender-affirming surgeries or administering puberty blockers or hormone therapy to patients under age eighteen • Bans out-of-state providers from providing telehealth care	• Disciplinary proceedings • Private action against the healthcare provider • $25,000 per violation
23. Texas[333]	• Bans providers from performing gender-affirming surgeries or administering puberty blockers or hormone therapy to patients under age eighteen	• License revocation
24. Utah[334]	• Bans providers from performing gender-affirming surgeries to patients under age eighteen • Create certification required to provide gender-affirming care • Restrictions on administering puberty blockers or hormone therapy to patients under age eighteen	• License suspension or revocation; fines • Damages from a medical malpractice action

332. S. 1, 113th Gen. Assemb., Reg. Sess. (Tenn. 2023).
333. S. 14, 88th Leg., Reg. Sess. (Tex. 2023).
334. S. 16, 2023 Leg., Gen. Sess. (Utah 2023).

STATE	PROHIBITIONS	PENALTIES
25. West Virginia[335]	• Bans providers from performing gender-affirming surgeries or hormone therapy to patients under age eighteen • Puberty blockers permitted with restrictions	• N/A (not in bill)
26. Wyoming[336]	• Bans providers from performing gender-affirming surgeries or administering puberty blockers or hormone therapy to patients under age eighteen	• Medical board discipline and licensing suspension

335. H. 2007, 86th Leg., Reg. Sess. (W. Va. 2023).
336. S. 99, 68th Leg., Reg. Sess. (Wyo. 2024).

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